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THE ROLE OF THE PSYCHIATRIST IN A GENERAL HOSPITAL*

BY M. RALPH KAUFMAN, M. D.

It is indeed a great honor to have been invited to be the Richard H. Hutchings memorial lecturer. Dr. Hutchings was already one of the grand old men of American psychiatry when I began my own training in the New York State hospital system many years ago. It was my pleasure to know him personally, although I could never count myself one of his intimate friends. To me, as a psychiatrist, who is also a psychoanalyst, Dr. Hutchings has a unique place in American psychiatry, since he was one of the early pioneers who recognized the importance of Freud's psychoanalysis and ably presented a psychodynamic point of view to American medicine. It would be impertinent for me to elaborate further on his many virtues as a man, as a physician, and as a psychiatrist.

* * *

The writer has selected the topic of the psychiatrist in a general hospital setting for discussion here for a number of reasons. The first and foremost is perhaps that this aspect of psychiatry has been a major personal interest for many years—through personal relationship to the Harvard Medical School under Dr. C. Macfie Campbell, and later Dr. Harry C. Solomon, through whose joint influence the writer first became interested in the general hospital as a psychiatrist—at Massachusetts General Hospital and then at the Beth-Israel. Even as a resident at Boston Psychopathic Hospital, which lies at the periphery geographically, of the cluster of general hospitals surrounding the Harvard Medical School, there were many occasions to answer consultation calls from these general hospitals. The type of cases that the psychiatrist was called in to see is a commentary on the changing climate of medicine in its relationship to psychiatry.

At the present time, the writer has the privilege of working in collaboration with a fairly large group of psychiatrists and adjuvant personnel—psychologists, caseworkers and others—in The Mount Sinai Hospital, New York City. This service, as at present organized, was first instituted in 1946, although Mount Sinai has had a long tradition of psychiatry as part of its over-all function.

*The Fourth Annual Richard H. Hutchings Memorial Lecture, Syracuse, N. Y., October 6, 1952. From the department of psychiatry, The Mount Sinai Hospital, New York City.

As a matter of fact, the current issue of *The Mount Sinai Journal* has an article entitled, "The Jews' Hospital and Psychological Medicine,"[1] which is of historical and chauvinistic significance since it reports several psychiatric cases from the first case record book of The Jews' Hospital, as Mount Sinai was then known, about one hundred years ago. It was one of the first hospitals in this country to institute a psychiatric out-patient service—under the direction of Dr. Clarence P. Oberndorf. The presence of a psychiatric unit in a general hospital is not something new, since there are many general hospitals which have had psychiatric divisions for many years. However, by and large, these psychiatric divisions were only geographically, and not functionally, related to the hospital. There are a number of reasons for this, and perhaps, in stating these reasons, the thesis will also have been presented for the present discussion.

There is an interesting relationship between the times and basic scientific concept. Somehow the intellectual and emotional climate at a given time in the history of science must be right in order that certain fundamental changes in theoretical concepts be accepted. It is not always certain that an apparent new truth becomes self-evident and acceptable. If neither the time nor the basic concept is appropriate, then it may happen that two aspects within a given discipline may exist side by side without having any intrinsic relationship to each other. The writer believes that this is so in the relationship of psychiatry to medicine; however true it may be, as has sometimes been stated, that since "traditionally physicians have descended from the witch doctor, the shaman, and the priest . . .," and, therefore, "since our ancestors treated by incantation and exorcisement, the psychic factor in the disease process has always been recognized. Indeed it would seem on superficial examination as if at one time in the history of medicine psychogenic factors were the only ones that were considered."[2]

As the writer has stated elsewhere, in an article from which the foregoing is an excerpt, he believes that to a great extent this is a misreading of history, since the witch-doctor may have thought of possession by a demon in an actual physical, rather than psychological sense. Be that as it may, medical textbooks have for centuries emphasized the role of emotional factors in all types of syndromes. This in itself, however, was not sufficient to relate the psychiatrist to the general body of medicine. He, on the other hand, either

through design or acquiescence, considered his special field to be restricted to the mental disorders as such and dealt both on a theoretical and pragmatic level with disease entities that manifested themselves, by and large, in disturbed behavior patterns that necessitated the withdrawal, either voluntarily or by coercion, of psychiatric patients from the community. It was only when a new frame of reference was brought into being by Freud, in his epoch-making clinical observations and theoretical conclusions, which made for a psychodynamically-oriented psychology of the human individual (and which in this country were paralleled, but not always in agreement, by the series of basic concepts constituting the psychobiology of Adolf Meyer), that the theoretical concepts enabled the psychiatrist to understand a broader spectrum of human behavior and allowed him to come into a closer relationship with medicine. Primarily this relationship was based on the fact that the physician as such has always had the task of treating not only disease but people.

The writer has already referred to his experiences as a resident in Boston in the role of a consultant. He well remembers, or perhaps since he is anxious to prove his point, should say that he remembers only, that when one was called in to see a patient it was because that individual was manifesting overt behavior of such a disturbing nature that even the medical interne could make the diagnosis of "nuts" (quote only); or else that the patient to be seen had become a management problem, and, therefore, the primary reason for calling in the psychiatrist was that he by law could sign certain colored papers under certain sections of the law which then enabled the hospital to be rid of a troublesome patient. This, of course, is an exaggeration to make a point, but essentially it represents the situation not too many years ago.

With the advent of a clinical and theoretical point of view, which incidentally Dr. Hutchings saw rather early and represented in American medicine, it became possible for the psychiatrist to enter into the great stream of American medicine. The psychiatrist became interested, not only in the dementia præcox cases and the manic-depressives and the unclassified psychotics, but also in patients and individuals who presented somatic complaints, in which there was no question about organic pathology, since organic pathology could be demonstrated in many of these patients through adequate medical examination. He became interested in the indi-

vidual and in the complex psychological and emotional factors which might etiologically and concurrently relate to all forms of illness. The two world wars contributed to this interest. Many psychiatrists know from personal experience the tremendously important role that psychiatry played in World War I and World War II, not only in the process of selection and treatment of the straightforward psychiatric syndromes, but also in all aspects of the practice of medicine. Many physicians were impressed by these observations and evinced an interest and sympathy for the psychiatric point of view.

Psychiatry, then, has become a kind of basic science in medicine, in many ways not unlike physiology and biochemistry. Psychiatry, almost by definition, has become an integrator and catalyst in the teaching of medical students, the training of residents, and the practice of medicine. The writer is not going to discuss psychiatry as a basic science here, but rather the psychiatrist's role as integrator and catalyst. Psychiatrists are all familiar with the field of so-called psychosomatic medicine, and its implications for the practice of medicine at all levels.

To return to the role of the psychiatrist in the general hospital: As a colleague of equal status with all other physicians in a general hospital, he is called upon to participate in the full activity of the hospital. Only by way of illustration, the writer would like to refer briefly to the organization at Mount Sinai Hospital. Administratively and functionally, the service is divided into several units—a 22-bed open ward in-patient service for adults, out-patient psychiatric clinics for adults, and what the writer believes to be the most significant division for the role of psychiatrists in a general hospital, a section of liaison psychiatry, whose psychiatrists are assigned to out-patient clinics and in-patient services other than the psychiatric service. There is a division of child psychiatry which is a smaller replica of the adult service. Perhaps the best indication of the role of the psychiatrist in a general hospital would be to indicate the type of patients, in terms of primary diagnosis, that are referred to the psychiatric service for whatever additional diagnostic and therapeutic measures the psychiatrist can offer, as a specialist, to the surgeon or the physician. In a previously published paper, the following patients with their diagnoses were listed:[3]

"1. Ulcerative Colitis
Psychoneurosis (obsessive-compulsive with depressive features).
"2. Ulcerative Colitis
Mental deficiency (obsessive-compulsive personality).
"3. Manic-depressive (depressed, hypochondriasis).
"4. Essential Hypertension
Schizophrenic, catatonic.
"5. Anorexia Nervosa.
"6. Fugue State, questionable catatonic schizophrenia.
"7. Ulcerative Colitis
Obsessive-compulsive personality.
"8. Diabetes Mellitus
Psychosis with depression and paranoid trends.
"9. Postgastrostomy
Hysterical personality type.
"10. Psychosis (paranoid state, somatic delusions).
"11. Ulcerative Colitis
Schizophrenia, type unclassified.
"12. Coccygodynia
Psychoneurosis, conversion hysteria.
"13. Duodenal Ulcer—postvagotomy and gastroenterostomy
Passive-dependent personality.
"14. Duodenal Ulcer
Passive-dependent personality in adolescent boy.
"15. Rheumatoid Arthritis, Amyloidosis
Psychoneurosis, obsessive-compulsive.
"16. Hyperthyroidism
Chronic anxiety state.
"17. Gastric Ulcer—postvagotomy and gastroenterostomy
Psychoneurosis, hysteria.
"18. Psychoneurosis (conversion, cardiac symptoms)."

This was an unselected group in the sense that it represented the patients on a ward of the psychiatry service on a given day. One has but to read the list of primary diagnoses to realize how far psychiatry and medicine have advanced in the utilization of basic psychiatric concepts in the practice of medicine. Here we see patients whose primary illnesses do not fall into the well-known psychiatric syndromes. Actually, it is only rarely that a patient with a schizophrenic or a manic-depressive psychosis finds his way to

the psychiatric service. This is because the basic philosophy, as a psychiatric unit in a general hospital, is to be primarily of service to the population of such a general hospital. Therefore, the psychiatrists work with those patients who come to the hospital, and most patients come to a general hospital because of illnesses whose symptomatology is primarily expressed in somatic manifestations.

The liaison psychiatrist in Mount Sinai, assigned to all services of the hospital, is at the very forefront of psychiatry, since his only duty is to work intimately with the attending and resident staff of each service, whether surgery, medicine, or one of the specialties. He is a free agent in the sense that he does not have to wait until he is called, but, being part of the over-all medical team, he is privileged to work with every patient on the service and to give whatever help is indicated whether at the diagnostic or therapeutic level. A parallel series to the one just given of patients whose primary diagnoses are as follows can be listed to illustrate some of the problems he deals with:

1. Sprue
   Neurotic character.
2. Hyperthyroidism
   Language barrier, plus conscious refusal to discuss self, anxious, depressed.
3. Myocardial Infarction
   Depressed because dependency wish frustrated on being sent home.
4. Pancreatitis
   Reactive depression.
5. "ACTH" Psychosis
   Psychotic reaction (ACTH) in case of lupus.
6. Contact Dermatitis
   Psychosomatic outlet for severe neurosis and depression.
7. CA of breast
   Anxiety state, no suggestion of danger of post-amputation depression.
8. Post-Cholecystectomy; long hospitalization; suicide threats
   Moderate reactive depression; no suicidal danger.

9. Depression—post-hysterectomy
   Anxiety neurosis, depression, severe; refer to Psychiatry OPD.
10. Hemi-paresis
   Conversion hysteria, recommend suggestion, reassurance, early ambulation.

Here again one sees that the psychiatrist in a general hospital relates himself to every aspect of the practice of medicine. His importance to the surgeon is to help him understand what is going on in a given individual. For instance, in elective surgery, he may give an opinion on whether or not the emotional factors are such that the procedure should be carried through; occasionally the psychiatrist is placed in the position of making the ultimate decision, not as to whether the patient needs surgery, but as to whether surgery should be carried out at a particular time. The psychiatrist or the psychiatric service may be assigned the task of preparing a patient to accept with a minimum of trauma the necessary surgical procedures.

One of the basic facts of life in regard to a psychiatrist in a general hospital is the simple and pragmatic one as to whether he is of any value to the other members of the staff. The surgeon or the internist is not interested, except in an academic way, as to what the psychiatric diagnostic label is or in what, to him, very frequently is an esoteric evaluation of psychodynamic factors for their own sake. He is, however, interested as a physician and as a practitioner of medicine in a colleague's help to understand and to be of practical assistance in the total evaluation and furtherance of treatment of any given patient. However, it must be emphasized that the practical help which a psychiatrist renders is but one step in his total integration into the general hospital. One can carry practicality too far and end up by having a highly mechanized approach to the problems of medical practice in a hospital. As the writer has stated before, a psychiatrist is a catalyst, an integrator. He has a great deal to contribute to medicine, but his contribution must be made primarily as a psychiatrist. The writer has no patience with the type of psychiatrist who tries to smuggle himself into medicine under false colors and who feels that it behooves him to demonstrate to the surgeon or to the internist that after all he, too, is a top internist or surgeon. A knowledge of medicine is essential, but no psychiatrist that the writer knows will

ever convince any internist, even a mediocre one, that he, too, knows the normal value of NPN. At the present time, although the approach is a holistic one, it is nevertheless impossible for every physician to be an expert in every branch of medicine, and one does not "sell" a psychiatric point of view if one disguises himself with a false face and pretends to erudition that is essentially superficial. The psychiatrist is a psychiatrist, just as the surgeon is a surgeon; and it is only as a psychiatrist, standing firmly based on his own discipline, that he can eventually demonstrate the value of his orientation in the understanding and treatment of patients.

At Mount Sinai, the psychiatric in-patient service is considered as only a minor part of the total psychiatric function. The psychiatrists endeavor to work with the patients on the parent services and to maintain the professional relationship of the surgeon or internist to those patients. The psychiatric contribution, if any, is to demonstrate to the internist that an understanding of the patient as an individual will enable the internist to function at his fullest capacity as a physician. The writer can cite many instances in which the psychiatrist on the various services of the hospital was able to contribute specifically in his role as psychiatrist, and as illustrations, would like to present the following incidents, reported by members of our staff.

Case 1

The patient was a 40-year-old, married woman who was admitted to the hospital with the complaint of pain in the abdomen and pain in the back. She was compelled to assume a grotesque, camptocormic posture while at the same time attempting to stroke an area in her back and in her abdomen where she complained of pain. She received extensive medical, and a surgical, workup. No abnormality to account for her symptoms was discovered. When her bizarre posture and the following personal history were put together, psychiatric consultation was requested.

The history was that this patient had made a hasty second marriage during the war, to a previously unmarried army sergeant. During the war, she lived comfortably on allotments from him and small supplementary earnings. On his return, he demanded his marital rights, and her disability promptly began. It was suggested that the woman's posture was well calculated, so to speak,

to prevent the marital intimacy which her husband expected. The psychiatrist was impressed by the following features: (1) She gave a straightforward account of her symptoms, including her primitive regret at having made a bad marriage to a man she did not like; she had handled her dislike of her husband in a furtive and evasive way, never quite confessing to him that she was frightened by his advances. There were other factors to indicate that basically she was a neurotic, inadequate woman. (2) There was no history that somatic disability, other than that of headaches, or "nervous indigestion," had been used as part of her reaction to an affectively-charged situation. Her reaction to her illness and pain was that of a search for a clinging and helpless dependency. This behavior was characteristic of her in more stressful situations. Her description of her pain did not have the fantastic elaboration oriented toward specific avoidance, or toward negation of, sexuality. (3) The psychiatrist, therefore, concluded that although the woman was neurotic and inadequate, she exhibited a reaction to an organic process that was appropriate for her neurotic personality. He suggested that this woman was suffering from an organic, intra-abdominal, undiagnosed process and that in addition she had the severe character disorder which her physicians recognized. Upon this basis, an exploratory laporotomy was performed, and carcinoma of the head of the pancreas was discovered.—(Notes from Sydney G. Margolin, M. D., liaison psychiatrist on the medical service.)

Case 2

A 'teen-aged girl on the ear, nose and throat service had a nasal plastic operation with a pedicle graft from forearm to nose, necessitating a cast and traction of the left upper extremity. Following this operation, she complained of sensory and motor disturbances of the left hand. This constituted a diagnostic problem of considerable importance: true neurological defect would require sacrifice of the operative gain; if the symptoms were on the basis of psychoneurosis, the operation need not be sacrificed if the patient's co-operation could be obtained. Because it seemed too early for signs to have developed, even if nerve injury had occurred, the neurologists in consultation could not be certain that the symptoms were on the basis of nerve damage. In their opinion this was most likely a hysterical conversion syndrome. The psychiatric examina-

tion revealed that this young woman did indeed suffer with a psychoneurosis of hysterical type. However, this did not necessarily explain the present symptoms. Hypnosis on two occasions served to satisfy the psychiatrist that the parasthesias and motor disability were on a neurological basis.

This information was of definite value in providing the ear, nose and throat service with specific diagnostic information on which to base a decision of major importance. A decision to sacrifice the pedicle graft followed.

In terms of follow-up, it seems likely that there was a second gain from psychiatric help, in that during hypnosis strong suggestion was made to the patient that the graft would succeed and that circulation would improve in the operative area. While this sequel may be questioned, the fact that the graft took, after an unusually brief attachment for collateral circulation, points to the probable efficacy of this suggestion under hypnosis. During the trying period in which the patient's panic was increased by the concern of her doctors and her family, the availability of a psychiatrist to provide reassurance and decrease her fear was of the utmost importance for the comfort of the patient as well as for the success of the procedure and maintenance of good patient- and family-hospital relationships.—(Notes from Alvin I. Goldfarb, M. D., liaison psychiatrist on the otolaryngology service.)

Case 3

A man in his early 30's was admitted to the surgical service for operation for a lung abscess. He was seen in consultation by the psychiatrist because of the patient's conviction that he would not survive the operation. This was remarkable in view of the fact that the patient had served in three armies—Polish, Free French, and American—during World War II, had undergone an emergency appendectomy during military action and had been subjected to countless real dangers during this time, without suffering any evident neurotic manifestations. It was impossible to dissuade the patient from his conviction or to expose the groundlessness of his fears.

During an interview, the following information was elicited. Shortly after the close of the war, the patient fell in love with a Dutch girl, caused her to become pregnant and then married her. Not long thereafter, he had an opportunity to come to the United

States which created for him a severe dilemma—whether to proceed to America alone, establish himself, leaving his wife in Holland until after the baby was born, or remain there with her. She urged the former course, and he reluctantly complied. After establishing himself in America, he learned that a son was born. Unfortunately, about two weeks later, the baby contracted a pulmonary ailment and died. He castigated himself for leaving his wife and felt that had he remained on the spot his connections with American medical personnel in the army would have avoided this tragedy. Although little attempt was made to point out the coincidence of these two pulmonary affections, an attempt was made to interpret his conviction that he would die from a chest operation as a manifestation of his remorse and guilt over his son's death. On the day following this interview, the patient, when asked how he felt about the impending operation, smiled sheepishly and stated, "I got over that foolish idea." Subsequently, the patient was operated upon and recovered without complications.—(Notes from Bernard C. Meyer, M. D., liaison psychiatrist on the surgical service.)

Case 4

A 49-year-old woman was transferred to the surgical service from gynecology for radical vulvectomy and exploration of the deep pelvic nodes because of malignant melanoma of the vulva. She had been told of the presence of malignancy, and that the chances were good that the tumor would be completely removed and would not recur. However, she lapsed into an agitated depressed state, and reassurance was of no avail. The surgeons were reluctant to schedule the extensive procedure with the patient so disturbed, and called for a psychiatric consultation.

It was ascertained that the patient's chief concerns were because she was afraid about her ability to urinate normally after the operation, and because she had heard that after the removal of "glands" she would no longer be a woman. She also feared that she would not have a vagina after the operation, that her scars would be ugly, and that she might have "caught" the cancer from swimming in dirty water. She had previously been reluctant to discuss this with her physician; some simple factual explanations were given to her; and diagrams were drawn for her to show what would be involved in the operation, and what would not be involved. The

depression and agitation subsided. During the days prior to the operation, the patient was seen daily, and new questions were answered. Conferences were held with the house staff, in which the patient's psychiatric formulations were discussed in connection with suggestions for managing the case. (Incidentally, this patient's mother had always complained of dyspareunia, and had died of some gynecological condition. The patient had constant pain with intercourse, about which she had never informed her husband; and she had the practice of voiding after intercourse for contraceptive purposes, ascribing her childlessness to the latter procedure.)

The patient underwent the operation uneventfully, and when seen on discharge appeared cheerful and eager to return home.—(Notes from Paul Kaunitz, M. D., liaison psychiatrist, surgical service.)

Case 5

A 40-year-old woman was admitted to the hospital because of a melanoma of the vulva. She was apparently inordinately panicky and disturbed at the impending surgery. The gynecologists felt that her fear was in a sense exaggerated and inexplicable, since she repeatedly mentioned the fact that she was quite realistic in her knowledge that this was a serious condition, probably malignant in nature, requiring radical surgery. Within five minutes after the psychiatrist visited her, she blurted out the fact that it was not the fear of malignancy itself, or even death, which bothered her much, but rather the horror of mutilation after which she might find her external genitalia so distorted that "she would no longer look like a woman." When she had confessed this basic anxiety and when she was assured truthfully that no such deformity would result, she was operated on without any undue terror and made a completely uneventful and successful convalescence.—(Notes from Mark L. Gerstle, Jr., M. D., liaison psychiatrist, gynecology service.)

Case 6

When a psychiatrist was first assigned to the medical service, he was frequently called to see elderly patients (over 65) who soon after admission showed confusion and a mental picture of disorientation and agitation. Frequently, on the nights of admission, these patients had been heavily sedated with barbiturates. It was explained to the house staff on several occasions about the rela-

tive difficulty older people have in adjusting to new situations, and that transitory confusion, and so on initially did not necessarily mean serious mental disturbance. Some idea of the effect of cerebral arteriosclerosis on cerebral function was given. It was pointed out in this connection how the use of barbiturates would merely increase the cerebral anoxia present and aggravate the overt mental picture. After it was demonstrated to the resident staff how, in several patients, reassurance and understanding, coupled with the use of chloral hydrate or paraldehyde, tided these people over the first day or so of hospitalization with complete clearing thereafter of overt mental symptoms, staff members began to feel more relaxed in dealing with such problems. The result is that now the resident staff deals directly with such problems, and the psychiatrist only learns of them incidentally.—(Notes from Edward D. Joseph, M. D., liaison psychiatrist on the medical service.)

Case 7

The psychiatrist on the surgical service was making "grand rounds" with the surgeon, who said to one of the patients, "Good morning, Miss G." The patient replied, "You have a nice haircut." Subsequent questions that the surgeon asked the patient about the patient's condition were answered relevantly. However, the psychiatrist was struck by the initial response which was either irrelevant or might have been a kind of friendly impertinence. He decided to study the case further after rounds and found that the patient actually had a mild toxic psychosis on the basis of a prolonged postoperative infection. The psychiatrist was then able to point out to the surgeons the significance of this seemingly innocuous remark of the patient.—(Notes from Paul Brauer, M. D., liaison psychiatrist on the surgical service.)

As another illustration of the role of the psychiatrist in a general hospital, the following brief report by Dr. Louis Linn, liaison psychiatrist on the neurology service, of work that he is doing in collaboration with the ophthalmological and neurological services, is of interest.

"Although psychiatric disturbances following cataract extraction have been known for many years, the problem has not been studied systematically. The psychiatry service in conjunction with the departments of ophthalmology, neurology, electro-encephalog-

raphy, social service and nursing studied 21 consecutive admissions for cataract extraction in an attempt to evaluate factors in the total picture. Twenty of the 21 patients showed evidence of organic brain damage, indicating that cataract is simply one external evidence of a widespread degenerative process, which affects the brain as well as the eye, and probably other parts of the body. So that what started as a psychiatric study contributed inadvertantly to our understanding of the pathology of cataract. We covered the eyes of these patients for a 12-hour period pre-operatively. Several patients reacted to this procedure with intense anxiety. These same patients tended to show the most marked psychiatric disturbances post-operatively. It became possible by this means to anticipate which patients would require special nursing care post-operatively. It was repeatedly possible to demonstrate that uncovering the eyes post-operatively had a dramatic anxiety-relieving effect, as did removal of side rails from the beds, early mobilization of patients from their beds and early return to their own homes, all matters of considerable importance from a prophylactic point of view. In addition, the material was instructive from a theoretical psychiatric point of view, shedding light on the psychological mechanisms of defense against anxiety and how these defenses were modified by organic brain disease."

These illustrative incidents come from the clinical experience of members of the staff and are presented as they were reported. Each one of these incidents represents another facet of the many types of problems that confront the psychiatrist in his daily work in a general hospital. There are a multiplicity of problems that arise administratively and professionally for the psychiatrist in a general hospital, but this discussion has touched on only a few. The writer has attempted to present a basic philosophy of the function of the psychiatrist in medicine and to reflect the factors that enter into the integration of psychiatry into medicine. It is his belief that this aspect of psychiatry has opened vast new areas and has posed many questions. It is a tremendous field for new types of research. There is a new possibility for psychiatry to validate many of its basic theoretical concepts through the utilization of the biological techniques inherent in the medical viewpoint.

Psychiatry has come back into medicine as a co-equal member in a scientific discipline and is making a noteworthy contribution. However, this new relationship is confronting the psychiatrist with

the necessity for a reorientation of some of his basic concepts toward a dynamic psychobiological point of view that augurs well for our field.

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CONSIDERATIONS IN THE DIFFERENTIAL DIAGNOSIS OF SCHIZOPHRENIA*

BY NEWTON BIGELOW, M. D.

Probably the factors which generally prevent psychiatrists from making a good differential diagnosis (let alone a good diagnosis) in schizophrenia are lack of time to develop a good history, to observe the patient adequately and to consider all of the facts carefully, providing the physician has lived long enough with cases to have developed a keen diagnostic "nose" for the disorder.

The need for a good diagnosis is probably clearest with respect to the initiation of proper treatment. Some patients badly need insulin-coma treatment early. Very frequently, too, the proper differential diagnosis has a strong bearing upon a medico-legal problem in a given case—in respect to prognosis for disability, for example. Finally, scientific progress cannot be made without proper labeling, as in the evaluation of treatment, or even in fundamental statistical research.

Recently, the writer has been concerned with the startling discrepancy in the statistics from the several institutions in the New York State Department of Mental Hygiene, with respect to admission diagnoses. Comparable hospitals serving comparable areas show extreme variation in the percentages, for instance, of admissions of patients with manic-depressive psychosis, as opposed to schizophrenia, or again even with reference to some of the organic disorders. Geographical or cultural differences have not accounted for these variations among the so-called functional disorders and the organic psychoses. At the First Conference on Psychosurgery,** held under the auspices of the National Institute for Mental Health, the matter of diagnosis and comparative statistics in this same aspect also came up. The statisticians and the clinicians expressed themselves then as being alarmed over the variability which existed in the data which came from contiguous states as it related to similar disorders. So far as one can tell at the moment these discrepancies depend primarily upon the personality, train-

*Address delivered at Veterans Administration hospitals at Northport and Augusta, N. Y.

**National Institute for Mental Health: Proceedings of the First Research Conference on Psychosurgery. Newton Bigelow, M. D., editor. Public Health Service Publication No. 16. Washington, D. C. 1951.

ing and background of the individuals charged with making the official diagnoses. Other factors, perhaps also not inherent in the clinical material itself, undoubtedly affect the reported data as well. By studied, consistent effort, it is probable that some of these factors may be controlled.

The ideal procedure, in order to make a good differential diagnosis, would include: first, a valid history from the patient and his family, containing at the same time a clear picture of his early emotional environment, his family and his pre-psychotic personality. In this connection, Federn* quotes Schwing's sweeping generalization "that all schizophrenes did not have true mothers," which contains more than a kernel of truth. Thereafter, thorough psychiatric, physical, neurological and laboratory examinations would be required, followed by a psychological work-up, including particularly the Rorschach test and any other indicated procedures. These data should then be supplemented by the patient's response to therapy, if by this time the diagnosis is not already sufficiently clear. It is also believed that the patient's reactions to certain substances will soon be an aid in regular diagnostic routine. Finally, time will help to clarify the diagnosis in a certain number of cases. Parenthetically, it does not seem to indicate, to the writer, shiftlessness for a psychiatrist to label a few difficult cases at the end of the year as undiagnosed psychosis if he can conscientiously say that the diagnosis is still not clear. A random review of 50 patients diagnosed five years back would furnish the reason for the last statement.

In attempting to decide that a given individual is suffering from schizophrenia, one should first rule out organic disorders. Certainly, with the procedure just outlined, little difficulty will be encountered except in the rare instance. The paretic with a schizophrenic set of symptoms is easily excluded by the organic psychiatric findings, the psychological report and, of course, by the serological and neurological positive findings. The paranoid arteriosclerotic is usually betrayed by his typical emotional lability and organic mental signs. Occasionally pre-senile patients present difficulty, particularly in the very early stages. Here, again, careful psychiatric, psychological and neurological examinations will point the finger at the proper etiology. Later, with x-ray and biopsy

*Federn, Paul: Ego Psychology and the Psychoses. Edoardo Weiss, editor. Basic Books. New York. 1953.

findings and the full development of all the signs and symptoms, the differential diagnosis is not difficult in the average case.

Long—and questionably—included in the organic group, are those patients labeled involutional psychosis, paranoid type. If one is conscientious, the writer believes that diagnosis of a certain number of these will give trouble. A few are very close to schizophrenia of the paranoid type, and there is the rare case which looks quite a bit like the so-called paranoid condition. But the character of the prodromal period, the inclusion in these patients of some typical involutional features and the complete setting will generally allow one to discriminate. Finally, these people do not do well on electric shock therapy, as opposed to the usual response of the paranoid schizophrenic.

Also, in the organic group, one must consider acute hallucinosis. The history and course in the usual case clinch the diagnosis. However, there are patients who are quite schizophrenic in their appearance. There are others who show overt symptoms and voice trends only while imbibing alcohol. Some time ago, a number of writers argued that the typical case should be placed either with the schizophrenic or with the manic-depressive disorders, indicating the clinical uncertainty which exists here. Noyes* expresses, as follows, his doubts about placing the paranoid reaction in the schizophrenic group: "Clinically it is convenient to describe an alcoholic paranoia, although its recognition as a true alcoholic psychosis is scarcely justified."

The paranoid condition has been mentioned. Here again, the need for a careful chronological history of the evolution of the personality and of the disorder is very necessary. The elaboration of the trend which, if one grants the original premise, would not be too inconsistent with reality, and the preservation of the personality are the signs ordinarily relied on for differentiation from dementia præcox. Admittedly, however, the differential diagnosis is difficult.

The manic-depressive psychosis very frequently poses a considerable differential diagnostic problem. Qualified psychiatric examiners are frequently in sharp disagreement over a given case where most of the facts are at hand. Again, the need for a careful history of the personality development to show the presence of either the characteristic cyclothymic or schizoid make-up is the first

*Noyes, Arthur P.: Modern Clinical Psychiatry. 3d edition. Saunders, Philadelphia and London. 1948.

essential. Prolonged mood swings in the history are likewise significant. Comparison, by the trained observer, of the trend of the manic as opposed to that of the productive schizophrenic can often distinguish the disorders. The degree of empathy present in the manic-depressive case is relied on by many but is purely a subjective matter, in our present state of knowledge. Some observers have had considerable to say about clouding of the sensorium in the acute stages. Others have quarreled with this view. The need to distinguish between apathy and depression, the need to recognize a depression masquerading as a somatic syndrome and the need to distinguish between the purposeless behavior and verbigeration of the schizophrenic, as opposed to the purposeful activity and flight of ideas of the manic, are shown by the use of the adjective, "pseudo-affective," and the former diagnosis, "allied to dementia præcox." Finally, all of us are given pause by the occasional case of a patient with manic-depressive psychosis, who, as he grows older, has severe manic attacks with greater frequency and gradually presents a chronic paranoid disturbed state.

The differential diagnosis between the psychopath and the schizophrenic occasionally causes difficulty, particularly if the individual has transient episodes of the paranoid variety. The history, the "cold amorality," the usual explosive emotional reaction and the absence of characteristic trends generally clarify the diagnosis. Psychological tests may aid therein.

It is when we come to the psychoneuroses that we frequently have our greatest trouble. In the writer's mind, the psychoneurotic and the schizophrenic processes are separate, individual developments, although experience during World War II would tend to negate such a conclusion. It is admitted, too, that the obsessive-compulsive is a first cousin to the schizophrenic. Further, it should be remembered that most personalities present some admixture of neurotic traits, which of course will not exclude the development of a schizophrenic process if the constitutional endowment is right and the current situation explodes it. Neurotic symptoms occasionally serve as a defense mechanism in latent schizophrenia.

To differentiate the psychoneurosis from schizophrenia a longitudinal view of the individual is again most necessary. The story of the development of the disorder is likewise most pertinent; and, in the difficult case, careful, time-consuming, repeated examinations alone may allow one to see the essential facts.

Writing on the subject of the differentiation of the psychosis from the psychoneurosis, Henderson and Gillespie* list some of their criteria. They point out first that in the psychoneurosis only part of the personality is involved, whereas generally there is a change in the whole personality in the psychosis. They go on to say that frequently there is no outward change in the individual suffering with a psychoneurosis, whereas generally this cannot be said of the psychotic individual.

For the psychoneurotic, reality has the same meaning as for the rest of the community. Thus, although there may be some quantitative change in the psychoneurotic, the qualitative change as seen in the psychotic is not apparent. They make the further point that rarely does one find distortion of language in the psychoneurotic. So far as the psychoneurotic is concerned, unconscious material gains only symbolic expression. Frequently in the psychotic, unconscious material is crudely manifested. It is also pointed out that true regression is seen in the psychotic patient. This does not occur in the individual suffering with a psychoneurosis. Even though the degree of insight is not great, most psychoneurotics recognize that they are ill, and a good number have some understanding, vague as it may be, as to the nature of their illness. It is true that some schizophrenics recognize that there is something wrong with them, but rarely can they identify the morbid site.

Here, then, are some general guideposts for sizing up the given case. They are not exact and certainly do not apply *in toto* to any one individual.

It is probable that speculation as to etiology does not help us with the diagnostic procedure. However, clear recognition of the dynamic mechanisms involved is essential in analyzing the forces at work in the case before us, and interpreting correctly the past behavior of the individual. His psychosexual development, his basic conflicts, his reaction to frustration, his handling of hostility, his responses to anxiety-laden situations all may give a key to the puzzle. From another view Muncie,** in discussing the essential nature of schizophrenia, said that "Bleuler named the reaction schizophrenia, by which he aimed to stress the most striking clini-

*Henderson, D. K., and Gillespie, R. D.: A Textbook of Psychiatry for Students and Practitioners. P. 151. 7th edition. Oxford University Press. New York. 1950.

**Muncie, Wendell: Psychobiology and Psychiatry. Pages 388-9. Mosby. St. Louis. 1939.

cal features and, as he thought, also the mechanism involved, in a splitting of the associative processes. He eventually had to assume a basic gliosis and his later contributions point to a dichotomy of 'primary' symptoms on an organic basis, and of 'secondary' symptoms, an essentially psychological superstructure." Thereafter, Muncie stated in the same discussion: "Meyers' concept of essential habit deterioration on a basis of a peculiar constitutional make-up has been the most useful theoretical foundation for modern work."

Schilder states very definitely with reference to the nature of the schizophrenic process, "I am convinced that schizophrenia is in the same sense an organic disease as is the manic depressive psychosis." He goes on to say, "I prefer to emphasize that in schizophrenia the basic functions pertaining to perception, action and judgment are chiefly perturbed by the conflicts and the regressions. This is a fundamental difference from the psychic disturbances one finds in organic processes affecting the brain tissue. I prefer to call the psychological disturbances observed in these cases, disturbances in the ego function." Federn* writes even more directly: "Metapsychologically, the primary schizophrenic process appears to be a functional deficiency, or even exhaustion, of ego cathexis; secondarily, it is used as a defense mechanism." And again: "In psychosis, the main damage consists of the loss of cathexis (mental energy charge) of the ego boundaries. As a consequence, we find in this condition a narrowing of the extent of the mental ego, ideas and concepts being still preserved; but the same ideas which normally form within the mental ego boundary and, therefore, are apperceived as mere thought, at once take on the character of a false reality when they occur outside the ego boundary. As the loss of the ego boundary cathexis becomes definite this false feeling of reality takes on the quality of being beyond any subjective doubt."

Thus, whatever one's orientation, in attempting to differentiate a schizophrenic process from a psychoneurotic disorder, it is necessary to develop a clear picture of the underlying psychopathology.

From the purely descriptive standpoint again, the observation of irrational behavior or the valid report of such behavior may be very good evidence of a psychotic process, despite one's inability to demonstrate the classical trends or symptoms. This fact is

*Ibid.

often forgotten in evaluating a patient, with reference, for instance, to a court action. Reference should be made again here to the lack of empathy ordinarily obtaining in the relationship between the schizophrenic and the therapist. This function is subjective and belongs in the field of clinical intuition, but many successful practitioners in the era prior to our present laboratory and gadget period owed much of their success to clinical intuition. There should be little difficulty in differentiating the apathy of schizophrenia from the *belle indifférence* of hysteria, it may be added.

In further evaluating such cases, it is essential to distinguish between the somatic complaint and the somatic delusion. A little time and understanding will enable one to form the proper judgment. Some neurotic fears are also difficult to distinguish from delusional formations. In one's thinking, it is necessary to separate carefully the dissociation in schizophrenia from that entirely different process in hysteria. The need to distinguish the conversion symptoms, or the compulsive ritual, from the schizophrenic mannerism is also worthy of note.

Most conscientious clinicians today are very loath to make a diagnosis of neurasthenia, although there is no doubt that the syndrome does exist. The writer believes that this tendency is a reflection of the fact that in the past many so-called neurasthenics eventually proved to be hebephrenics. The same contention can be applied very aptly to hypochondriasis. It is the writer's belief also that most hypochondriacs are early schizophrenics.

Hoch and Polatin* have described one group of schizophrenics who strongly resemble neurotic patients. The writer believes that all of us have known individuals of this type, have misdiagnosed them and probably have mistreated them. Hoch and Polatin, in describing the process, point out that these patients show no deterioration and no trends. However, if they are followed long enough they are observed to suffer brief psychotic episodes, and later some develop frank schizophrenic pictures.

In this paper, Hoch and Polatin refer to Bleuler's basic schizophrenic patterns, specifically the primary symptoms of schizophrenia. These include disorders of association, rigidity of affect, ambivalence, and dereistic thinking. The authors remark that

*Hoch, Paul, and Polatin, Phillip: Pseudoneurotic forms of schizophrenia. PSYCHIAT. QUART., 23:2, 248-276, April 1949.

many psychiatrists are uncomfortable about a diagnosis of schizophrenia unless Bleuler's secondary symptoms, trends and motor signs, are present. They go on to say, however, that the primary symptoms are the essential ones and that in this group of cases evidence can be adduced of the presence of these if careful study is undertaken. They point out that with sodium amytal the presence of inflexibility of affect and even occasionally of some trends, can be demonstrated. In a certain number, the Rorschach responses are helpful, particularly in those showing unpredictability, variability, and the so-called "contaminated responses." Outbreaks of hostility, particularly toward parents, the existence of what Hoch and Polatin call "pan anxiety" and "pan neurosis" are, they feel, significant findings. Careful examination will also show condensations, concept displacements, feelings of omnipotence and vague, contradictory explanations of symptoms, in contrast to the careful explanations given by the usual psychoneurotic. Review of the histories usually indicates good evidence of psychosexual immaturity. The authors emphasize that the superficial appearance of such a case is that of a classical psychoneurosis, that the usual symptoms are present in over-abundance and that the patient may go on for years presenting such a picture.

The writer wishes to close these remarks by emphasizing again that the chief requirement for a good differential diagnosis of schizophrenia is ample time—time to develop and review a good history, time to examine carefully and observe the patient, and time to consider all of the facts fully.

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FEMALE TRANSVESTISM AND HOMOSEXUALITY*

BY HYMAN S. BARAHAL, M. D.

There is relatively little in the literature on the subject of transvestism, particularly the female type. A definition of terms would appear to be indicated in order to differentiate this manifestation from the related, but dynamically different, condition known as fetishism.

Karpman,[1] in a lengthy report on a case of transvestism, refers to the condition existing in individuals who are heterosexually inadequate and who, in order to relieve themselves by masturbation, dress in the clothes of the opposite sex, this desire to wear the other sex's clothes disappearing as soon as the masturbatory act is completed. One would question the correctness of referring to this as transvestism, as it is more in line with the concept of fetishism. The transvestite generally assumes the role of the opposite sex because of strongly ingrained inner emotional needs which are not subject to fluctuating changes to meet temporary requirements. Fenichel[2] refers to transvestism as a masochistic perversion and quotes the ideal figure, Hercules, clothed in woman's garments, and serving his mistress, Omphale. He believes that there is some relationship among transvestism, fetishism and homosexuality. The fetishist, he states, is unable to accept the lack of a penis in women; can love only when he has supplied his female love object with a symbolic penis. The male feminine homosexual, also because of castration anxiety, is incapable of loving a being without a penis and therefore solves his Oedipus complex by identifying with his mother and seeking the love of father or a substitute. According to Fenichel, transvestism has a two-fold significance, fetishistic and homosexual. Instead of coitus with the mother or her substitute, the fetishist enters into a relationship with her clothes which he brings into close relationship with his body, particularly his genitals, the patient himself representing a woman with a penis.

Fenichel makes a significant statement, "It is true that this hypothesis makes feminine perversions and the whole subject of the castration complex in women all the more problematic. Indeed,

*Read at the Downstate Interhospital Conference of the New York State Department of Mental Hygiene at the New York State Psychiatric Institute, April 8, 1952. This paper also embodies the views presented in a paper before the Society of Medical Psychoanalysts, January 31, 1952, at the Waldorf Astoria Hotel, New York City.

one receives the impression that they are, to some extent, different in character from perversions in men. Female transvestists seem to be simply women who covet the penis and, out of the desire to possess it, have identified themselves with men."

London and Caprio[3] speak of transvestism as a form of compulsion neurosis in which the patient's desire for the genitals of the opposite sex is displaced to the clothing of the opposite sex. A similar view is expressed by Stekel and Gutheil,[4] when they refer to cross-dressing as a desire to be identified with the opposite sex.

Although when superficially considered, there seems little question as to what constitutes transvestism, the problem becomes more complicated on further study.[5] Generally speaking, the trouser type of garment is considered male and the skirt female. This has not always been the case; and throughout the history of mankind there have been periods during which both men and women have normally worn clothes which today would be looked upon as demonstrating transvestism. Even in modern times, among the most northerly races, trousers are worn by both sexes alike. Further south, the men retain the trousers, and the women assume the tropical or skirt garb. In Shanghai, women wear trousers, whereas in Hong Kong, only a short distance away, skirts are the correct form of dress. The impression has been offered that the reason for European woman retaining the tropical garb was her relative inactivity, as she was generally confined to the house. However, where women are more active, they don the male type of garment. Belgian women working in mines and Swiss women tending cattle always wear trousers. On the other hand, the males of the Scotch highlands wear the skirt or kilt, as trousers would be impractical in the wet heather. It, therefore, appears quite obvious that when one considers the subject of transvestism, cultural factors have to be taken into consideration. For instance, a certain amount of transvestism is accepted as normal among women in our present day society in the wearing of slacks, short hair and tailored clothes. This may account for the fewer cases of female transvestism than of male reported in the psychiatric literature. Yet any deviation on the part of the male is considered abnormal.

A number of cases of female transvestism have been historically documented,[6] but, unfortunately, the psychological determinants can only be surmised. A woman known as James Barry, Sr., was inspector general of the English Army Medical Department. She

was referred to as "The most skillful of physicians but the most wayward of men." Lady Hester Stanhope, niece of William Pitt and married to Sir John Moore, was known to assume masculine attire. Dr. Mary Walker adhered strictly to masculine dress for 50 years. She was related to James Whitcomb Riley and Robert G. Ingersoll. She was graduated from Syracuse Medical School, entered the Union army and was commissioned as assistant surgeon, undoubtedly the only such commission in the American army until recent times. She later became a well-known feminist and lecturer on the rights of women. Her only marital venture ended in separation after three weeks.

The following is a report of analytic work with a case of female transvestism which in many ways resembles that reported by Stekel and Gutheil, even as to the limitation placed by the patient on therapy. In Gutheil's case, the patient stipulated that she wished to come for treatment, chiefly to get permission to wear men's clothing so that she would have no difficulty with police authorities and that she did not wish to be changed in any way. The present patient wrote as follows to the writer prior to treatment:

"I am always starving for spiritual love, seeing that it is such a crime and sin for me to have sex with a girl. I never did with the ones I loved and respected. But those I did not care too much about, I made them turn against me. This seems to be a crazy way to prove that I really cared. I feel best only when I am neutral and not involved in any love affair. I am love-starved, yet get sick with fear every time I fall in love and it is always with girls. I feel trapped completely and cannot take it much longer. These splitting headaches and conflicts are unbearable. If you can help me to remove these feelings of anxiety and headaches, I will be grateful to you. However, as much as I wish to be helped, I don't want you to change me so that I will begin to wear dresses."

For orientation purposes, a short résumé will be given of this patient's life history. However, the greater part of the material will come from progressive analytic sessions including a very active dream and fantasy life.

This is the case of a 22-year-old girl who was born illegitimately when her mother was only 17 years of age. She has never seen her real father and only recently has learned who he was. Adding to the problem of her illegitimate birth was the fact that her mother lived in a small village where everyone knew her and there was

considerable gossip about her. The mother rejected the patient very early in life, and began to board her with various friends and relatives. Between birth and the age of 14, there were eight or nine such changes of residence, the longest period in one place being about six years between the ages of eight and 14 years with a maternal aunt. She completed the ninth grade at 15, and this terminated her education. Following this, she was self-sufficient in that she worked in various factories or did housework. Since early childhood she has had an ungovernable desire to be a boy and has insisted on wearing boy's clothing. Also since childhood, she has shown sex interest in girls; and, as she grew older, she would become alarmed at such interests and would change her jobs frequently so as to avoid too close contact with girls. When she was 19, she met a passive homosexual male who was in the military service. Just before he was to go overseas, he urged her to marry him so that she would be entitled to his government allotments. They married, but the next day he left for Europe, and she has not seen him since. She had herself admitted to a hospital* when, on one occasion, she received a letter from her husband that he expected to be discharged from the army within a few weeks and wanted to return to her. She became panicky and sought help.

Analysis was carried on with considerable difficulty because of strong character resistance which persisted for a number of months. Although she gave the superficial impression of being cooperative, there was at first no emotional participation in the relationship on the part of the patient; her manner was formal, exact, polite and over-ingratiating.

First Session

Dream: "I'm supposed to have a date with a homosexual girl. She goes home to dress and I'm waiting for her. I wonder whether she will come out in a dress or slacks. I am very glad when she comes out in a dress."

Associations: "I don't like girls who wear slacks. I am afraid of their domination. When I was a little girl, I resented my mother going out with men and leaving me home alone. I resented the men my mother went out with. Recently a girlfriend with whom I had been carrying on a relationship, met a fellow and had

*Pilgrim (N. Y.) State Hospital.

an engagement party. I felt very hurt by it. It was as if she had left me for someone else, a man."

This session would indicate her competitive feelings toward men because they took her mother from her.

Second Session

"I had a fight with a patient who called me a hypocrite for going to church. Just before the fight started, I had a very severe headache. After the fight my headache disappeared suddenly. Whenever I give vent to my anger, my headaches disappear. Maybe I am a hypocrite. When I was a little girl, my aunt, who raised me, kept telling me that I will have to go to church frequently so as not to turn out to be as bad as my mother. I have always resented church. Yet, when I go into a church, I generally have a religious feeling come over me. As a little girl I knew two boys. One was very nice and treated me respectfully; the second one was an effeminate boy who was mean to me. I preferred to go with the second one even though he was no good. I was a tomboy and wanted to play with the boys, but they chased me away. I resented it very much and I used to get headaches. I could have beaten up any one of those boys but didn't.

"Later in life there was a woman I didn't like, and my headaches kept getting worse and worse until finally I beat her up so badly, that she had to go to a hospital. My headaches cleared up immediately. I almost think that the relationship between a man and a woman is such that the woman always gets beaten up. My stepfather used to beat my mother frequently."

This session again indicates her strong need to identify with a man and the sado-masochistic elements of her neurosis. The relationship of her headaches to introjected aggression is rather prominent.

Third Session

"I met a bisexual attendant. The world seems to be full of them. She is a little sadistic and I seem to enjoy that. It almost seems that they like to be mean so that I would slap them. One girl I know was happy when I slapped her around. I guess I like that too. When I was a little girl, I remember my stepfather wanting to sleep with my mother; she didn't want to and he beat her up. He then chased me out of the house. I felt very guilty as if I had

been responsible for the whole thing. When I was a little girl, I was a tomboy and only enjoyed playing with boys. When they found out that I was a girl, they wouldn't have anything to do with me."

(Are you afraid of being a girl?)

"When I was 12 or 13 years old, my stepfather, as well as two of my uncles, seduced me and I lost all respect for them. One uncle, whom I had previously respected very much because he would tell me that sex was disgraceful and advised me not to have anything to do with boys, he goes ahead and seduces me. When I was in grade school, I had intercourse with one boy. This was the first time I ever had any relations. I became very frightened. I feared that I was pregnant. I worried for four months. I really did gain weight, but I guess it was due to eating too much. Whenever I'm unhappy, I eat a great deal."

This session again shows her attitude toward sexuality as existing on a sado-masochistic level; that it's the man who injures the woman, which always places her in a precarious position.

Fourth Session

"My girlfriends tell me not to trust you—that you are going to let me down—not to trust any man. At the dance the other day I was having a good time dancing with a girl when I saw the other girl I was interested in, who is going to get married soon, and I felt frightened and sick. Then some other girl told me that the marriage is off, but this information was wrong. My mother always left me for a man. She had several of them. I'll never forget one time she had a date and had no place to leave me. She took me along but warned me to say that I was her sister and not her daughter. Toward the end I forgot and called her, 'Mommie.' She got awfully angry. The man didn't see her again and my mother blamed me for breaking up this relationship. My mother always made me feel that she would have been happier if I had been a boy. She made me promise when I was about 10 years old that, when I grew up, I would take care of her. I told you that I had my hair cut like a boy when I was three years old. I just remember something happened about then. There was a red-headed girl about seven years of age who took me and a little boy in the barn and I know that something sexual happened, but I don't remember

exactly what; but I was very frightened. Shortly after that I cut my hair and wanted to wear boys' clothes.

"On the playground the other day I told one of the girls, 'I found out something new about myself. I enjoy being hurt.'" (Was that really the interpretation made last time?) "Well, you did say perhaps that I needed attention from my mother so badly that I wanted it even at the expense of being hurt. Its funny but I still get the feeling occasionally that I'm going to win my mother. I must still love her despite the way she treated me. Recently I stopped over in a place on Times Square and made a recording of the song, 'To The One Girl I Love,' and sent it to her. Yet, at times I hate her."

Fifth Session

"Some patient was telling me about Greenwich Village and how wonderful it is. She is a pretty sick woman. At times I like her but at other times I hate her. This time, when she talked so glowingly about Greenwich Village, I blew up."

Dream: "I had a technicolor dream about a mannish girl I know, not the one who is getting married. She had on a nice red shirt, pants and had lots of pretty girls around her. I had mixed feelings about her. I admire her and would have wanted to be in her boots. Yet I felt jealous of the other women and wanted her for myself."

Associations: Her associations with this dream dealt chiefly with her attitude toward her mother. "I resented her running around with men. At the dance Friday I danced with another girl, and I purposely went past the girl in the dream in order to make her jealous."

This session again shows the competitive feelings this patient has toward people seeking her mother's attention and affection, and brings forth another facet to her search for women as a means of making her mother jealous.

Sixth Session

"I had a dream. I think it was about you."

Dream: "I am working in a laundry. [She actually did work in the hospital laundry.] I'm at one end of the room and all the other women working there are at the other end of the room. Something seems to draw me to that other end. Perhaps I have to go

to the ladies' room. I go over there, go to the ladies' room and then start teasing one of the girls, pretending to feel her up and she becomes passionate. My common sense tells me to return to my end of the room to work, but after I get there, I change my mind and try to go back where the women are. A man tells me to go back where I belong. He uses force on me to keep me from the women. Something seems to strike me in the head and I want to kill him, yet I can't get myself to do it. I begin to scream. I wake up with anxiety and find that I was being awakened by an attendant for breakfast."

Associations: "The man in the dream reminds me of both my first and second stepfathers. Both were very cruel. They resented me even when I visited on occasions as a little girl. I also resented them because I felt that they kept me from my mother. Since I've started analysis with you, I've often wondered whether you are trying to force me to give up dressing like a man. I am all confused about men and women. I had a dream recently about a masculine girl here at the hospital to whom I'm attracted, but I like to tease her and get her angry. At times she appears to be like herself. At other times she is like my mother and then again like my husband. My husband is a neurotic, very attached to and dependent on his mother; yet he hates her. He loves my mother more. When I married him, he told me that he would like to be the woman in the family. He looks masculine though."

"Why is it I like to be hurt at times when I feel bitchy? The other day one of the women had an argument with me and she struck me across the face with a towel and I had a lot of pleasure out of it. When I was a little girl I was a tomboy and liked to play with the boys. They resented me and frequently beat me. I got a lot of pleasure out of that despite my anger. In recent years, with many women, I have actually provoked them to strike me. Do you suppose that this is due to a feeling of guilt that I have because of my hostility toward them?"

This session reveals her confused feelings regarding her sexual role and her difficulty in deciding which role to assume. This is also the first indication of any strong transference feelings involving the analyst. She expresses the strong desire to destroy anyone who wishes to place her in the role of a woman, which to her involves considerable danger.

Seventh Session

"I had three dreams last night."

Dream 1:. "The masculine girl I like tells me she loves me, but my mother writes to me that she is sick and needs me. I leave the girl and go to my mother. I find that she lied to me and she wasn't sick at all. I get angry and leave her and go back to the girl."

Dream 2: "I go home to visit my little six-year-old sister, the six-year-old adopted sister. I'm very affectionate toward her. My mother comes up and starts nagging me. I feel she hates me and I begin to hate her terribly."

Dream 3: "I am dreaming of a masculine girl. I can't decide whether I like her better dressed as a man or as a woman. I decide I like her better as a woman."

Associations: "My mother was a terribly hostile individual. When I was a little girl, up to the age of 14 years, she used to lock me up in the house so that she could go to work all day. I had no chance to play with other children. A couple of times I broke out of the house and raised hell. I think I did that to get even with her. I was recently introduced to clitoral masturbation with considerable guilt. I get no satisfaction any other way. The only orgasms I've ever had with either a man or a woman, occurred when they put their tongues to my clitoris. Also when I have fantasies of masturbation or intercourse with women, they consist of clitorises touching. I am worried about my little sister. I would like her treated differently than I was, but I'm afraid my mother is making a neurotic out of her too. My biggest aim in therapy is to be able to live with a woman and have no anxiety about it. But now I'm so filled with hostility toward everyone that I can't live with any person, man or woman. To be a woman has always meant something terrible. All the men I've ever known have insulted and ridiculed women. I have disliked the manner in which men dominate women. I hate being dominated, even by women; yet at times I seem to enjoy it."

This session points out poignantly this patient's terrific and endless search for a mother, with persistently expected frustration as well as her feelings of vulnerability as a woman.

Eighth Session

"There was a patient out of the hospital with whom I fell in love and lived with. She is now back in the hospital in a very depressed

state, and I have considerable anxiety over it. I feel guilty over the fact that I may have been responsible for her return. It's funny that her nickname is 'Skippy,' and on several occasions I have called her 'Lucky' which is the name of another girl I like. All women seem to be the same to me. Some patient told me that 'Skippy' was going to get married. This upset me very much. I have insisted that she tell me, but she denies it. I feel greatly attracted to her. When we lived together, she was like a mother to me, but at other times I felt like the mother and she was my little girl."

Dream: "I'm back home in my mother's house lying in bed with her, in my second stepfather's bedroom. In the dream she has divorced him, which made her free to be with other men and I feel like a young fellow competing for her love. I have on boy's clothes. There is a sound at the door and she tells me to get out of bed because her third husband is coming. I feel very rejected. As I start going out, a young man comes in. He is violent looking, short, Spanish or Italian. I go to my room and start packing."

Associations: "This man who walked in looked like my husband, who was very attached to my mother and she to him. When I was a little girl, there was a sissified boy who visited my home, who liked my mother very much and she him. I didn't like him. She used to invite a lot of children into the house and wanted me to play with them, but I didn't want to. I had a weird feeling during the dream because, actually, when I was a little girl, she didn't let me sleep with her."

In this session her competitive feelings with people who, actually or in fantasy, attempt to take her mother from her are quite obvious. It is essential for her to be a man in order to gain the love of her mother.

Ninth Session

"I received a letter from my mother telling me that she is marrying her third husband. I've been quite upset about this. There's one particular girl on the ward with whom I have been having trouble. She prays a lot and reads the Bible constantly and then reads filthy stories. She must be a hypocrite. I can't be hypocritical. I want people to know just what's what. That's why I wear masculine clothes."

(Isn't that somewhat of a hypocritical act?)

"But if I wore dresses, that would be living an emotional lie."

(Perhaps there are other factors involved?)

"I suppose by wearing a man's clothes, I am sticking my nose out for a punch; almost as if I were looking for ridicule and punishment and asking to be hurt. When I first began to menstruate, I asked my uncle, who was a prize fighter, to fight with me and not spare his punches. I wanted him to think of me as a man rather than a girl. He carried out my suggestion and beat the hell out of me."

Another facet of her transvestism is apparently her need to suffer. This psychic masochism demands that she be ridiculed and made to suffer. It is interesting that she chooses the onset of menstruation, which physiologically initiates her into femininity, to denounce her womanhood and to proclaim her masculinity.

Tenth Session

"I have a very severe headache."

Dream: "A man and a women, both middle-aged, are coming out of church. They had just gotten married and both look irritable and neurotic. They decide to dodge everyone and go off by themselves in the mountains."

Associations: "What do you want me to tell you about the man? That he is you? I had a dream recently about my first stepfather of whom I knew very little, but in my mind he is associated with the 16-year-old boy whom I liked very much when I was 12. Although this boy was very nice to me, my aunt, with whom I was living at the time, objected to my seeing him. She told me that he had a bad reputation. Yet, she thought that this other boy, who was a homosexual and cruel to me, was alright for me to go with. This aunt was very mean to me. My uncle was all right, but she dominated him completely. It seems that I have always been subjected to sadistic people. My mother was very mean to me when I came back from the hospital last time. Also, my second stepfather wanted to have sexual relations with me, telling me it would clear up my nervous condition. He beat my mother a great deal. Is there such a thing as real love between people?"

(You have always professed the love of women and yet you keep describing women who have been mean to you.)

"I guess I really don't love them. I hate them. As a matter of fact, I can't remember a single woman with whom I had a close

contact whom I really loved; whom I didn't try to hurt. I liked my mother best when I could think of her as a little girl and dependent on me. Perhaps that has something to do with my wanting to be a man so I could take care of my mother."

In this dream, we have the first indication of any feeling of closeness to a man, with a fantasy of marriage to the analyst. We also get some indication of the meaning of homosexuality to this patient. It implies, not a love relationship, but one based on domination, control and hostility.

Eleventh Session

"I've been thinking about what I told you last time, that I hate women. I guess I really do. Every woman I've ever thought that I liked, I really wanted to hurt, but, why should one want to be with people one hates? Perhaps you have to be close to them to hurt them. I've been dreaming a lot since I last saw you, but I don't remember exactly what about. I think they are mostly sexual dreams of being raped by a man. [Up to this point the patient has been extremely ingratiating and polite toward the analyst.]"

(What is your attitude toward me?) "I know realistically that you are a very nice person. Yet I can't help but feel that you have a streak of nastiness underneath. You remind me a great deal of my second stepfather who frequently showed his mean streak. My uncle was a very nice fellow too. Yet, at every opportunity he made sexual advances toward me. One time he drove me out in the woods and tried to rape me. I guess I get suspicious when a man is nice to me."

This session indicates the patient's marked fear of injury by a man. Every relationship she has ever attempted with a man has ended disastrously for her. Her conception of a sexual relationship with a man is one fraught with danger and involves mastery of and rape by a man. Yet, a transference relationship is being developed with the analyst.

Twelfth Session

"I am very angry with one of the attendants on the ward. She is stupid, narrow-minded and thinks that we patients are that way because we have poor will power; that, if we only tried, we could get well."

(Why are you angry?) "She reminds me of my mother. One time, when I was a real little girl, I hurt my eye and she called the doctor. After he treated me, my mother told him she had no money to pay him. He became angry. She became very upset and bawled me out for getting hurt. No one has ever been kind to me. Even a psychiatrist at Bellevue Hospital told me one time that nothing could be done for me, that the only thing for me to do was to go to Greenwich Village and live with girls. The only man who ever showed any sort of kindness toward me was Louis, with whom I lived for a while. I have often wondered if there was something wrong with him to care for me. [Here there was a discussion of her low self-esteem, which is further borne out by the clothes she wears, indicating her low estimate of her role as a woman.] I guess you're right. It seems that I have always had a need to suffer. I need eyeglasses very badly; yet, when I get them I somehow manage to lose them or to destroy them. When I was a little girl, I complained about my eyes and my mother told me that I was imagining it. Later, when a definite diagnosis of hyperopia was made, my mother bought me some glasses, but I purposely broke them with the feeling that I was hurting her. One of the girls I lived with for a while, enjoyed beating me, but she told me that she also suffered by doing that. Whenever she beat me, I could tell that she was hurt and I therefore enjoyed it." (Here a discussion was entered into regarding masochism as introjected hostility.)

This session further develops the strongly ambivalent feeling about her mother, whose rejection and punishment she resents and yet expects and enjoys as a means of self-castigation. The role of psychic masochism as aggression comes out clearly.

Thirteenth Session

"I always have headaches when I leave you. [Discussion of her feelings of hostility toward the analyst and her over-ingratiating manner as being a mask for this.] I think of you as being a threat, in a manner of speaking, because it is your intention to cure my neurosis so that I won't have homosexual feelings toward women. Somehow you produce the same feeling in me that my stepfather did in making me compete with him for my mother. There is an attendant whom I like very much who was going to get married, and shortly after the engagement party, they broke up. [The patient smiles while relating this.]

"You asked me why I smiled. Do you mean to imply that I am glad to see the marriage broken off? I guess I've always thought of a man as being a threat in taking some woman away from me, and I am therefore glad to see impending marriages crack up. In most cases when I loved women, they were either married or in some way involved with a man." (At this point her character resistance was gone into. Although she has been taking an intellectual part in the analysis, there has been very little emotional participation.)

"I guess I've always been that way. Even when I was a little girl. It was a sign of weakness to show any emotion. My mother used to punish me for every little thing that I did or didn't do, and it finally became necessary for me to be very secretive. It has always appeared to me that I would appear weak if I laughed and cried like other people do."

In this session, the negative transference involving the analyst becomes more evident as well as the driving need to take a woman-mother away from a man.

Fourteenth Session

(The analyst is wearing a pink tie.)

"Gee, that's some tie you have on, but it makes you appear sissified. [Discussion of her resentment of anything "sissified" or effeminate.] As a little girl I resented a boy whom my aunt wanted me to play with because he appeared to be a sissy. I preferred to play with rough boys and told them to be as rough as they wanted with me, and to forget that I'm a girl. When I was six years old, I played with a pretty, little, blonde girl, and in the game I always took the role of the husband, who worked as a butcher, and I resented very much when this little girl asked me to hold a doll because that would be sissified." (Discussion of her masculine clothes as also signifying the same attitude. She apparently considers the role of a woman unacceptable and to be avoided.)

"My mother always made me feel that to be a woman is bad. I remember her always telling me that she wanted a boy instead of a girl. My mother always went out with a lot of different men to bars to drink, and she took me with her. I resented these men a great deal because I felt they were preventing my mother from being with me more. I felt then that if I am to have my mother to myself, I have to be either as good or better than the men she went

out with. A couple of days ago I put on lipstick for the first time in my life. I asked another girl how she liked it, and she said she liked it very much. That was a great surprise to me because I always felt that girls liked me as a man rather than as a woman. Some of the girls, however, have been kidding me because, for the past two weeks, I have begun to let my hair grow long."

In this session, the patient continues to dwell upon her competitive feelings with men as a means of gaining her mother. However, some change appears to be developing in that she is beginning to experiment with the use of lipstick and letting her hair grow.

Fifteenth Session

(The patient is under considerable tension today.)

"I hate all women. I have reached the point where I can't stand to have them around me. They annoy me, give me headaches. I feel like hurting them. I am very much attached to this married woman, and she shows me a great deal of love. I like her very much, but it frightens me. I told her to hate me. She is married but doesn't get along with her husband. [A discussion of her ambivalent feelings toward women.] I would like to have them love me, but I'm always afraid of being injured if I get too close to them. I felt that way with my mother. I also feel that way toward men. Take yourself, for instance. In your nice sort of a way, you are sadistic; for, don't you hurt people by confronting them with their problems? I look upon you as someone who is trying to force me to love people, and I don't think I am capable of it."

This session points out her strongly ambivalent feelings toward women as related to her experiences with her mother in childhood when every attempt on her part to form a warm, close relationship with her, resulted in frustration. She has built up a defense which involves the formula that close relationships are dangerous and should be avoided. The resistance to therapy is quite evident.

Sixteenth Session

This session is characterized by marked resistance, long silences, and a generally irritable manner. She attributes her feelings to her emotional upheaval involving the married woman to whom she is rather attached. She cannot decide whether she loves her or hates her. The patient had begun to grow her hair with the intention of getting a permanent wave in the future, but when she

visited the hospital beauty parlor yesterday, one of the patient beauticians insisted that she looked better in short hair and proceeded to have her hair cut again, which procedure the patient did not seriously object to.

This session indicates the strong resistance which this patient is capable of bringing forth in defense of her neurotic structure.

Seventeenth Session

"I am feeling much better today. My headaches are almost entirely gone. Lately my hostility toward women has almost overwhelmed me. The woman I am interested in was away for a few days and I was miserable. I am very much in love with her; yet, at times I hate her. The other day I was having a pleasant conversation with her when she got up and walked over to talk to one of the men. I was burned up. [Laughs.] I suppose you'll tell me that this means I am competing with men and think of them as taking the affection of women away from me. Well, maybe you're right. I really don't want the women sexually. I just want them to care for me. Sex has always been distasteful to me, either with men or women. I suppose my mother had a great deal to do with that. On a number of occasions I formed attachments with various women until they began to make sexual passes at me and then I began to hate them. There was a young girl at home whom I liked very much until she asked me to live with her and I became angry and left her. She later married and then I began to care for her again."

(You seem to be interested in women who are attached to men?) "Yes, I seem to be attracted to women with men. I have never felt guilty about hurting men. Most men I've ever known ridiculed girls and thought of them as being inferior."

Dream: "Doctor K. [on the hospital staff] is at my bed. He asks me if I am homesick and I answer, 'Not lately.'"

Associations: "As much as I have always hated my mother, I always go back to the home town at every opporunity. Lately I have been feeling more secure and thought that perhaps I wouldn't need my home as much. Perhaps there has been a change in me. I like this Dr. K. He seems to be a very nice, even-tempered person."

This session points out, not only her eternal search for a mother in every woman she meets, but also the utilization of this act as a

means of hurting the man from whom she takes the woman away. Further change is occurring, however. She is beginning to be more secure, and to show at least a partial capacity for displaying warmth toward a man.

Eighteenth Session

"I've been feeling well all week. I'm very happy. There is a blonde patient on the ward with whom I've struck up a close friendship, but she is becoming very possessive and is trying to alienate me from my feelings toward the married woman. Whenever I begin to talk to the latter, she tells her things about me to make her jealous. I guess I'll have to drop the blonde. I just wrote my mother advising her that I want to break up with her."

(Why does that come up now?)

"I don't know—just that my mother always stood in my way of going out with girls. She told me that she would rather see me dead. I half suspect that she was jealous of my friendships with girls. Now that I think of it, when I was living at home, I frequently brought girls home and kissed them in front of my mother just to make her jealous, as if to say, 'You see you don't love me, but I can get others to do so.'"

(This, then, is another reason for your being attracted to girls, as a means of making your mother jealous?)

"I guess so. This blonde made me boiling mad the other day. She showed me a couple of 'hickeys' made by her husband just to make me jealous and she did. She wants me to come and live as a boarder with her, but I don't want to do that. I want to have her all to myself."

(It is quite true that in your relationships with women, you have been constantly seeking a mother. But no amount of fantasy will change the fact that you are not a man, but a woman.)

"Crazy people can do that. [Laughs.] I know I am a woman but I want to continue to act as a man. I'm reminded of the fact that when I was four years old, I was very much attracted to a little boy in the neighborhood, but my attitude toward him changed when my mother went out of the way to shower attention and affection on him in front of me, and made such remarks as wishing that I had been born a boy. My attitude toward him changed immediately and I began to hate him. Now I don't want to be a woman and I don't want to be changed. By the way, you told me that any

time I wanted to leave the hospital, you will let me do so. Does this offer still stand?"

(Her resistance to change was pointed out to her.)

This session shows a third reason for her choice of women as love objects. If the mother, a woman, does not love her, there are other women who do. Although the patient has shown considerable improvement up to this point and is under less tension, yet there is considerable resistance to further change, with emphasis on the fact that she does not wish to be changed to a woman.

Nineteenth Session

"I have been having splitting headaches since yesterday. I think it involves this feeling I have toward the married woman. She told her husband she wants me to stay with her for a couple of weeks when I leave the hospital. I have the feeling that she is using me to hurt her husband. I don't like to be tied down. I want to be free. This has happened so many times to me before that I want to avoid it. Whenever I get too close to a woman, I begin to feel hemmed in. I also feel guilty in starting a marital rift."

(Yet you always seem to be attracted to married women. Perhaps that is what you want?)

"Yet, in fights between my mother and stepfather, I frequently took his part because I knew she was wrong in running around with men."

(Why the headaches?)

"I guess it's because I feel guilty about this affair I'm having. I suppose in a sense I'm hurting both her and her husband. Yet, I'm not hurting either. I don't cause problems between husband and wife. The trouble is already present before I come into the picture."

(There is a discussion of her cold exterior with little emotional display during the session.)

"I've always been that way. I was punished so many times for showing emotions as a child, that it was safer for me not to. When I went to the movies as a child, I just sat quietly by myself. I wouldn't even get up to go to the bathroom when necessary because I was afraid of criticism. Criticism was so banged into my head that it has apparently remained with me. There is something I have never told you. When I was 20 years old, I slept with a married woman while her husband was in the next room. The next

morning I decided to leave town and stole a bicycle which I sold to the husband for $20. I felt very happy about it, but also guilty."

(Guilty?)

"I suppose I could have gotten him in trouble if he were caught with stolen property."

This session indicates at least a partial origin of her fear of displaying emotion, her fear of punishment by a mother figure. Also her competitive attitudes toward men in her struggle for the love of the woman—mother—is again apparent.

Twentieth Session

"I don't know what to talk about. Sometimes I get the feeling you're sadistic. I don't know why. You certainly haven't acted that way. Maybe its my own feeling of wanting you to be sadistic."

(Why?)

"I've always picked sadistic girlfriends. This one girl wanted me to be mean to her. I purposely acted nice to her to get her angry. She would slap me around and I would laugh. That would make her blow up. It was my way of being cruel to her. With my mother, whenever she was cruel to me, I would do the same thing. I would act as if it didn't bother me and I felt that it hurt her more than if I would get angry and shout or cry. The woman to whom I am attracted is away and I feel better. I'm getting to feel that I shouldn't have anything to do with her because she is married and, since the explanation regarding my attraction to her has become clear to me, I don't feel very happy about being interested in her any more."

(Becomes quite embarrassed.)

"The last time I was waiting to see you, I had a fantasy that you were my father, and I liked the idea very much. Until I was 12 years of age, my mother kept telling me that my father was dead. I was satisfied with that explanation, but now that I know that he isn't dead, I've often wondered if I shouldn't look him up. Yet, I know that he wouldn't want to see me. He is married, and his wife probably doesn't even know about me."

Dream: "A very attractive blonde woman and I go to the barber shop in order that I may have my hair cut. The barber keeps me waiting and waiting, while he keeps talking to the fellows and, then, without paying any attention to me, he walks out with the fellows. I feel very angry. I think that he hates me."

Associations: "I've been growing my hair lately, and there has been conflict about it. Most of the girls I've known want me to be a boy and keep coaxing me to cut my hair. At home the barbers resented my coming to a men's barber shop and purposely gave me messy haircuts. Others just refused to give a girl a boy's haircut. The other day, while I was waiting to see you, you were busy seeing male patients. A feeling came over me that you cared more for them than you do for me. I felt the same way I did with my mother, when she kept giving me the impression that she wanted a boy instead of a girl."

(Discussion follows of the role of the analyst as the barber and her fear of being rejected by him. She admits that she has had misgivings about the analyst being nice to her, as no other man has ever shown any consideration for her.)

This is the first session to indicate any definite conflicts along Oedipal lines. To be sure, this is only a larval reaction, as it does not involve a full demand for the sexual love of the father and hostility toward the mother figure. There is, rather, an identification of the analyst with the mother figure, with the fear that even he favors the men in preference to her. Yet, it demonstrates a definite attempt to gain a father surrogate's love.

Twenty-first Session

"I blew my top last night with the married woman I like. We were preparing some coffee and a bite to eat, and, somehow, I was left out. I walked out in a huff and she came after me and tried to humor me. If there is anything I hate, it's that. I hate any sentimentality. It makes me appear as a weakling who needs someone's coddling. Suddenly she appeared like my mother to me and my anger welled up, and I began to bawl her out. My mother was like that. I never knew where I stood with her. Usually she did everything possible to hurt my feelings and yet when she felt that the townspeople were persecuting me, she would become very tender toward me. I didn't know whether I was coming or going. When I was with her, I was always wrong and made to feel that I wasn't wanted, and, yet, when at the age of 15 I left to live with my grandmother, she kept calling me frequently to come back."

Dream: "I'm walking all by myself on the street. Lou, the man I lived with, is walking along with a fellow and a girl. He walks

up to me and kisses me. I get all upset with myself because, on the one hand I like it, and yet I don't want to show that I do."

Associations: "I like Lou. At times he acted very effeminate and at other times like a man. I liked him better when he was a man. This other fellow I disliked because he was always trying to take Lou away from me. The girl in the dream, I don't recognize. I didn't like Lou when he wanted to be the girl and wanted me to be the man. My mother, too, was changeable that way. At times she treated me as if she wanted me to be a girl and at other times, a boy. The same thing goes for this married woman. At times she is very domineering and possessive. At other times she is very gentle. I don't like domineering, masculine women."

This session introduces some contradictory material. Although she has previously maintained that she wants to be a man, she now states that in her relationship with men, she wants the man to be masculine and she feminine. It is to be noted that even in her relationship with men, the prototype is the mother, who played a dual role as both a man and a woman, as at times she was very domineering and at other times gentle and feminine. The patient's confusion as to which sexual role she will assume is still a predominant factor in her thinking.

Twenty-second Session

"I've been filled with hostility and headaches ever since seeing you, although I feel better now. I had a fight with a girl who had been saying mean things to me. This married woman, with whom I had formed a friendship, and I discussed our relationship as being unhealthy. I told her if I get well I will still be friendly with her, but not on a homosexual basis. I got a letter from my mother, signed, 'Love, Mother,' but all I can see is hate. My feelings toward her are all mixed up. It's a mixture of love, hate, pity, disgust. One time during the war, we were working together in a factory and she was flirting with some of the men there. I thought I would like to have her a little to myself. I invited her for a couple of drinks, and she started making love to a married man who was already in trouble because he had made a young girl pregnant. I burned up and I bawled him out, and he promised to stay away from her. When I was 17, I was living away from my mother and she invited me to visit her, but then tried to keep me there. She took me out to get me a drink and just to get even with her, I

drank too much. My usual way of taking out anger with her was to rush out of the house and dash madly down the street on my bicycle. I had five different bicycles and I would drive recklessly down the street. On one occasion I was trying to cross the street and a woman driver tried to make a turn. We both waited for the other. I got very angry and shot ahead and she did the same thing and she hit me. I wasn't hurt, but she was scared to death."

(Discussion of this incident brings out the fact that she could have prevented the accident as she had a feeling that the woman was going to start, but she was very angry with her.)

"I also drove a car once and hit my girlfriend. I swore I wouldn't drive again. These women here talk about their love for women and I keep telling them it is not love, that they really hate these women. I certainly see it in myself. They claim they don't love men; yet, I've always gotten along better with men than women. The women I have known have had a sadistic reaction. The more you hurt them, the better they like it. They like to be beaten up. I guess I do at times too. [Discussion of the love relationship as a constructive rather than a destructive force, and the significance of pathological jealousy.] My hair is still growing and I'm glad. The girls are making fun of me. They want me to cut it off."

In this session she continues to work out her sado-masochistic problems and is beginning to recognize that what she previously considered a homosexual love for women, was based on domination, possession and sadism.

Twenty-third Session

"There is another woman who is getting friendly with me. I like her, but she wants me to be sadistic toward her. I also have crime on my mind, thoughts of stealing and getting arrested. What do you suppose this is due to? Is it that I want to be punished for something by being arrested? I know of people who seem purposely to get into trouble so they can be arrested. [This sounds very much like your situation with your mother when you were a little girl, when you wanted to be punished.] I used to want to be close to my mother, for her to love me, but I was afraid to show my feelings. It would have been a sign of weakness to show emotions. Somehow I had the feeling that if I showed emotions, I would be made a sucker out of."

Dream: "There is a fellow lying in bed, talking to a girl. I'm in the room and am very upset and I want to hurt someone and I make some nasty remark about him being engaged to me once."

Associations: "This fellow and I used to work together in a factory during the war. I liked him a great deal. However, he was sadistic. He used to throw knives at me as a joke, and once nicked my finger. My feelings were mixed about him. I hated him too. He used to embarrass me. We would go into a bar and he would order a glass of milk or a soft drink."

(Why should that embarrass you?)

"That was sissyish."

(You are always on guard against being considered a sissy. What would you do if you were really at a bar and wanted a soft drink?)

"I wouldn't do it. People would laugh and I would be hurt."

(You are afraid of being hurt? Is that why you don't show your true feelings?)

"I've always been that way. As soon as I start feeling soft for a person, I start changing in the opposite direction. In my family showing emotions was wrong. If my mother had only beaten me, it wouldn't have been so bad, but this constant nagging. That was hard to take."

(Apparently you had some tender feelings toward this man?)

"Yes, but I couldn't express my feelings because he was so mean. He looked something like you."

(What are your true feelings toward me?)

"I'm embarrassed to tell you, but I like you very much. Yet, when I start feeling this way, I say to myself, you must have a mean streak too, although I know that it is not true."

(You apparently don't show emotion because you fear it might result in injury to yourself. Your hard demeanor is only a defense.)

This session brings out a greater freedom in expressing tender feelings toward men, although with considerable trepidation about being injured in the process. Oedipal problems, which previously appeared to be practically lacking, now become more prominent.

Twenty-fourth Session

"I feel terrible. I hate myself because I have such hatred against the woman I thought I loved. She wants me to continue with her

and I want to break off the relationship. I am sadistic toward women who care for me and I like women who are sadistic toward me. I have a feeling that everyone on the ward is talking about our relationship. I don't want any sexual love from women. I just want to be near them. I don't like to continue the relationship with her because she is married and I'm sorry for her children. I've done some pretty terrible things in my life. I've slept with men for money and feel ashamed of myself."

Dream: "The police are chasing me because I did something wrong. I run to the house to hide and a boy and a girl there protect me. The girl starts playing up to me sexually. I am confused. I don't know whether I'm a boy or a girl. I don't trust her because I feel that she wants sex. I begin to talk to the man who is very nice, and my feelings toward him are more decent. I feel torn between them."

Dream: "I'm walking in a school yard, angry, passing other children, I'm confused about something. I return a book to the library and then walk to the wrong rooming house, but then I go back to the right one."

Associations: I don't trust women because they want sex from me which means that they want me to be the man. I know that I'm not a boy, that I never can be one; yet, I despise being a girl Boys are so much more clean-cut and not catty. The boy in the dream was very nice. I've enjoyed relations with some nice boys. Most boys despise a woman they have had relations with. They talk about it. In the first rooming house in which I lived, there was an older man who was like a father to me, but he had something wrong with him. He didn't want women sexually."

(You felt safe with him?)

"You know who you remind me of—some storekeeper at home. I didn't like him. When I look back at the men in my family, I can see why I distrust men. Whenever I trusted them they tried to seduce me."

(Are you afraid I am going to seduce you?)

"No, I know you're sincere; yet, there is something in the way of my completely trusting you. My attitude toward women has always been rather peculiar, even as a little girl. I like to associate with attractive girls, even if they are mean to me. It made me

feel like a big shot to be recognized by these attractive girls; yet, with homely girls who openly showed their affection for me, I was sadistic. It seemed to play up my own feelings of inferiority."

This session demonstrates at least one facet of her feelings of guilt, and need for punishment as related to her hostile feelings toward women or mother, as well as her guilt over sexuality. Her relationship with the analyst has made her wonder whether her estimate of men in the past as being dangerous, has been justified.

Twenty-fifth Session

"I'm working in the kitchen again and am very happy because I'm with the attendant I like. Yesterday I got through in the kitchen early and started on my way to the ward, but when I got to the door and knocked, no one answered. I knew the attendant was in the dining room and that I had to wait about one-half hour. I became very angry. It reminded me of the time when I was a little girl living with my aunt and uncle. They would go off to the movies and parties and I would have to wait at the door for hours in the cold winter until they came back. I had had a key, but lost it and for punishment they wouldn't give me another one. I'm still mixed up about my feelings toward women. These feelings vary between passion and hate. This attendant I like is rather sadistic toward me and yet I seem to enjoy it; yet, when I'm gentle toward her, I like to picture her as a sweet little girl and I'm the fellow. I used to picture my mother that way too, as an immature, childish person. In many ways I'm like my mother.

(Maybe you pictured yourself as a little girl in the way you would have liked to have been treated.)

"You mean the way I would have liked to have been treated by a man, my uncle? He was really a nice guy, but most men I've been attracted to have been mean and sadistic. Take the male attendants here, they have no respect for women. They make filthy, sexual cracks about them which makes me very angry."

(Why?)

"I wasn't raised that way. I guess to me sex has always been filthy."

(Discussion follows of her low opinion of herself because of her sexual drives—which explains her attraction to men who abuse her because she is not entitled to a nice man.)

Dream: "I'm riding in a car with people and we pass a huge building which seems to be a jail. I remarked that it looked like one of the hospitals I have been in."

Associations: "As I woke up, it occurred to me that the building looked like the Veterans Hospital that my uncle was in for a permanent disability resulting from World War I. He recently sent me a post card with a picture of the hospital. That same day the female attendant told me about her husband and little boy being injured in an automobile accident and had to be taken to the hospital for a short while. When I think of my uncle, I'm reminded that he was the only decent man I've ever known, just like a father to me. I frequently wanted to kiss him and be with him, but my aunt always got angry when I did that and threatened me. She was insanely jealous of him. In many ways he reminds me of you. You know, some of the attendants and patients have been discouraging me from coming to see you. They tell me to leave the hospital before it is too late."

(Like your aunt trying to keep you from your uncle?)

"In a way the building in the dream reminds me of this hospital. It's like a voluntary jail because I came here of my own accord. In the dream I had a happy feeling. I also felt frustrated. I wanted to come in there but something kept me from it. Maybe that's why I hate women because they keep me from men. My mother was very jealous of my attentions to my stepfather and, whenever I was angry with her, I would take my stepfather and go off for a few hours."

(By your anger and hatred, you actually expressed fear.)

"You mean, I'm really afraid of the women I hate?"

On leaving the analyst, after this session, the patient wishes him a Merry Christmas in a very friendly, tender manner, shakes hands and blushes. Asked why she blushes, she says that she is still embarrassed at showing any emotion.

This session brings out the patient's hostility and competitive feelings toward women as being actuated by their interference in her attempts to form a warm relationship with men. She responds to this by anger and with an attempt to take the man from the woman, resulting in feelings of guilt. Her self-hospitalization, therefore, assumes the character of punishment and repentance for her hostile feelings as well as for forbidden sexual aims. The

fact that she is now able to show a degree of warmth toward the analyst, is an indication that her fear of punishment by a forbidding mother is becoming considerably lessened.

Twenty-sixth Session

"I've decided on one thing quite definitely and that is that I can't live with a woman. They drive me whacky. They are so emotionally unstable, I don't know what to expect next."

Dream: "Skippy [a woman with whom she had previously had a love affair] is on a high building and I'm trying to reach her, but she is always beyond my reach. In the dream she hates me, but I'm trying to get her to love me. I get an airplane but still can't reach her. I feel very sick about it."

Associations: "Skippy was a patient I met here and although I was advised by the doctor against it, I continued to see her afterward. We had some drinks together and when she became upset again, and had to be returned to the hospital, I felt very guilty, as if I had been responsible for it. She is very much like my mother, very neurotic, and I never knew where I stood with her. At times I felt she hated me and I would get headaches as a result of this. I think what started the dream was that I was having an argument with the patient I had been attracted to, and I was very upset. She is very unpredictable and tries to dominate me, and I resent it. I developed a headache. In the dream, there seemed to be another woman with Skippy, but I don't know who it was. Somehow I have a feeling that my mother dominates the whole picture in the dream. My friends have been telling me to stop the analysis because they think I'm getting worse. Actually I think I'm a lot better, but they don't like the fact that they can't dominate me as much now as they used to, and there isn't as much need on my part for suffering."

In this session, the patient is beginning to recognize that she cannot be successful in the search for a mother by assuming neurotic relationships with women. There is also some recognition of the nature of her sado-masochistic attitudes toward women and her need for suffering has been lessened, though this is interpreted by her friends as unfavorable.

Twenty-seventh Session

(The patient is in a happy mood.) "I'm still working in the kitchen and like it very much. I ran into my girlfriend and the sudden thought came over me that she was my mother. She told

me I was getting worse and I should stop seeing you. By that she meant that I was standing up for my rights more now. When I asked why she thought I was worse, she laughed and said she really thought that I was better. I forgot to tell you that, during this last Christmas week, I dressed up as a girl one day, and I felt quite feminine, but I received so much teasing from attendants and patients that I took my dress off."

Dream: "I see my girlfriend and I love her very much. I become angry when her husband and another man, who was either her brother or her father, also pay attention to her."

Associations: "All I remember about the dream is of being alternately happy and angry over the situation."

(Discussion follows here of her feelings of competition with other men for the love of the mother.)

"My mother did have many men. It is peculiar that she tried to alienate me from all my friends and relatives. She always had something bad to say about all of them, but when I was with her, she wasn't very nice to me. She always kept telling me that I was going crazy."

We note an increasing ability on the part of the patient to express her feelings to the point of dressing like a woman and feeling happy over it. However, she still responds too readily to the criticism of other women, and to her need to gain their favor.

Twenty-eighth Session

This session is punctuated by considerable resistance, irritability, complaint of headaches and hostility toward women. She emphasizes repeatedly that she does not wish to dress as a woman. When asked if she is afraid of being a woman, she responds that she cannot tolerate the criticism and the ridicule by others. She is willing to admit, however, that in many ways, she helps to create the situation which will result in ridicule. "I guess I have a need for punishment."

Twenty-ninth Session

"I had two dreams last night, but I don't remember them too well except that they had to do with a man I lived with for a while. During the dreams I had the feeling that I loved him and would like to be with him. I am still very much attached to this girl, however, and that makes me very unhappy. She wants to give up her husband and be with me. One day I saw a man who was making a

play for her. He grabbed her impulsively and kissed her, and she seemed to respond. It made me sick. When I lived with the man I mentioned, I felt very insecure too. He was very effeminate and homosexual, but was very tender toward me; yet, I always wanted to hurt him, particularly when he insisted that I stay away from women. He wanted me to give up Greenwich Village. There was a man who was in love with my boyfriend who visited him regularly and brought him gifts. When my boyfriend responded to him, it made me very angry."

(There is discussion of the double identification. As a man her boyfriend wanted to take her away from women—mother. As a woman, however, he had other men attempting to take him away from the patient.)

"I seemed to enjoy hurting him, just as I would have enjoyed having him hurt me, but which he never did. No matter what I did, he responded with kindness. Even as a little girl I enjoyed being hurt. I got pleasure out of being beaten up by boys. I had a dog I enjoyed hurting."

(Discussion follows of the basis for her masochism.)

"I had a feeling that if I am hurt, my mother would pay more attention to me. I used to want to hurt my mother. I guess it was a form of rebellion. I created a reputation in town of being a drunkard, although I drank very little, and my mother used to say to me that I was disgracing her.

"Some of the girls want me to grow my hair; others want me to cut it off. I don't know how I feel. Sometimes I feel like cutting it off. One thing I am sure of is that I don't want to be a girl."

(Is that what you really mean?)

"Maybe I'm afraid of being a girl."

The various facets of her masochism come out in this session, among them being masochism as a means of punishing her mother, also a means of punishing herself, because of guilt.

Thirtieth Session

Dream: "My mother comes to take me out of the hospital. I have a talk with her and she seems all right. I'm not afraid of her. Suddenly she begins to hallucinate and I become frightened and refuse to go with her. She forces me out of the building, but I run back in again. I prefer to be in the hospital. All along I am worried about two suitcases I had packed and couldn't find, and am

afraid that someone may have stolen them. I wake up with a splitting headache."

Associations: "I received a letter from my mother which was pretty nice, but she accused me of lying to her when I told her I hadn't received stationery from her. I had also inquired about my little brother and she wrote not to worry about him, that, if any other two children had received as much care and attention as we had, they would be more appreciative and would show more respect and love for their mother. Before I began my analysis, I would have felt very guilty after such a letter, but now I was more thoroughly convinced of my mother's maladjustment. She never gave me the thing I really wanted—affection. Sure, she gave me material things which made very little difference to me. I'm worried about this girlfriend of mine. I think she is cracking up. I told her the other day that she is like my mother. At times she acts very friendly toward me and suddenly she becomes very unreasonable. The other day I tried to kiss her and she drew away as if she were afraid of me or didn't like me. She has been asking me to leave the hospital and go to live with her, but, because of her emotional state, I can't make up my mind. The fellow, who has been playing up to her, seems to upset her. She has also had trouble with her husband."

(You seem to resent both the husband and the other man.)

"My mother used to sleep with various men and I felt left out of things. She would make me sleep on the couch if she had a man with her."

(Attempts to disclose her associations to the packed suitcases only yielded the fact that she kept her belongings in two packed suitcases. The sexual significance was not forthcoming.)

"You notice that my hair is growing quite long. I can't decide whether to cut it off or make it up in a feminine way. I'm not quite ready for that, I guess."

This session shows a significant change in her attitude toward her mother; whereas, previously, she felt guilty over her unconscious hostility toward her mother and responded to this by masochistic behavior, she now is beginning to recognize the mother's own emotional instability and neurotic needs. One can conjecture the meaning behind her dreaming that her suitcases are packed, ready for a trip, and yet that she is not quite ready to take it.

Thirty-first Session

This session is punctuated by considerable resistance, the patient's manner is distant, and her productivity is diminished.

Dream: "I spend the night at your house as a friend. Next morning you come down the stairs and kiss your wife and children affectionately. I watch and try to figure out whether you really love them or have hatred toward them. My mind plays tricks on me. You and I get into your car and you tell me that I should get my hair cut and then you would take me to another state to see other doctors. I'm hoping there might be a chance of being turned into a boy physically. I want to get a job as a tree-cutter in the woods. I go over to see a girl about it. She drives a truck hauling logs to the mill. I envy her. She reminds me of a homosexual girl cab driver I knew in Greenwich Village. The woods remind me of my stepfather and I hauling logs to the mill, which I enjoyed doing very much."

Associations: "I cut my hair again. All I want in treatment is to clear me of my headaches. I don't want to be changed into a girl. The cutting of hair and trees in the dream may have something to do with my wanting to cut treatment. I belong in Greenwich Village. Before I started treatment, I had lots of guilt about my sadism toward other girls and I suffered over it. Since I began treatment, I've begun to realize that they enjoy my hostility as much as I do. It's therefore a mutual thing."

(Why your sudden change in attitude since you last saw me?)

"I feel hostile toward you. I don't know why. You've been quite wonderful and everyone likes you. It must be that I have no capacity for loving anyone. In the dream I had the feeling that I would want you as a father, but only if I could be a boy. When I worked with my stepfather at logging, I had a wonderful time and felt that I was on an equal level with him, but, as soon as he began to make sexual advances toward me, I became very angry and threatened to cut him up with a knife. When I go to Greenwich Village, I want to look enough like a girl so that homosexual men would leave me alone, and enough like a boy so that homosexual women would be attracted to me."

(In the dream you stand off a distance watching me show tenderness toward my family.)

"I didn't care. I had no feeling about it."

(Afraid to show your feelings?)

"I've always been that way."

This new resistance was precipitated by the fact that the patient saw the analyst driving his car with his family. She became very upset and, immediately thereafter, had her hair cut again.

Thirty-second Session

"I suppose you wonder why I had my hair cut. I just like it that way, so why shouldn't I have it?"

(You say it as if you were in rebellion against someone?)

"My girlfriend wanted me to grow my hair, and she'll probably be angry."

(Why do you rebel against her?)

"She wants me as a girl so she can dominate me; yet, she lets this married man show attention to her. He's a real rugged guy with hair on his chest. There is nothing sissyish about him."

Dream: "I'm in my home town walking along with my girlfriend on the way to the movies. A man comes along and starts talking to her. She seems to have a crush on him and is happy. I'm hurt and walk away by myself. The neighbors are watching, and, in my resentment, I tear off my tie and put it in my pocket and want to go off and steal something."

Associations: "This girlfriend is like my mother. She has lots of men and likes to hurt my feelings. I'm also reminded of my aunt whom I loved very much. Some man liked her, but she paid no attention to him, and he followed us to the movies. He finally made her pregnant and she married him. I've always thought of neckties as being sissyish. I like men who are rugged and don't wear neckties. I gave all my neckties away. To me, stealing is also a sign of being rugged and manly, like the gangster type."

(A discussion of her resistance against treatment and cutting her hair off as a rebellion against the analyst.)

"I feel more attached to doctors who have some problems of their own, because I have problems and they understand me better." (This is obviously a resistance to treatment, since you cannot be helped by people who have serious problems of their own.)

The patient is still reacting with hostility toward men who, in her fantasy, take her mother away from her. Her defense against

this is to be as rugged as any of them. In her relationship to the analyst, she is building guards against the recently developed tender feelings toward him, which, to her, represent a threat.

Thirty-third Session

"I'm all upset about my girlfriend and that man who is paying attention to her. She seems to be falling for him. I will have to give her up. What makes me angry is the fact that she is a married woman, and I can't stand a woman who is unfaithful."

(Is that what upset you or is it the fact that you feel left out?)

"I feel jealous. I had similar feelings with my mother and her men friends."

Dream: "Two patients are having a fight, and they curse each other. They are supposed to be good friends. I feel sick and angry about it. I blow my top and begin to scream at them, and tell them that, if they don't stop fighting with each other, I'll bang their heads together. I feel like killing. I wake up with a terrible headache."

Associations: "Before I met my girlfriend, I was friendly with one of the girls in the dream who is quite feminine. This girl then became friendly with this second girl in the dream who is quite masculine. Now they are really on the outs and argue a great deal. I hate to see them unfriendly toward each other." (Do you really?) "Maybe I'm jealous and would like to be back with this girl."

(A discussion of the meaning of her headaches follows—and her realization that hostile wishes coming true, even in fantasy, have something to do with them.) "I've been brought up to feel that even thinking mean thoughts is bad. When I was a little girl, I felt guilty over asking to be loved by my mother when she had so many men to love. It was as if I did wrong in feeling that way, as if I wasn't entitled to her love as much as they were, and that she couldn't love both them and me at the same time."

(There was interpretation of her psychic masochism as being based on the premise, "I am wrong in wanting or receiving mother's love. Therefore, I should be punished.")

Thirty-fourth Session

"What do you think of Ingrid Bergman?" (She is referring to the recent marriage of the actress to a man who had divorced his wife.) "I hate some of the attendants who criticize her behavior."

(Do you identify yourself with the actress?) "No, I identify myself with Rosselini, who was in the position of taking a married woman away from her husband. This girlfriend of mine has another man making up to her. I'm all upset about the situation. I recognize the fact that it was a similar situation with my mother. I tell this girl that she reminds me of my mother. My mother had various men and when she consorted with them, I felt completely left out. At times I pictured myself as a young man courting her, and she seemed to enjoy that relationship. She hurt me terribly by having men friends in front of me, and I would anger her by telling her of my girlfriends. I told my girlfriend that I recognize that our relationship is an abnormal one, and that I'm looking forward to meeting a non-neurotic man. She gets angry when I tell her that. I think she resents you very much."

The patient apparently continues to identify herself with men and is using the analyst as a means of making her girlfriend jealous so as to remain in competition with other men. Here, then the analyst is identified with a woman—her mother.

Thirty-fifth Session

"I blew my top and still have headaches over something that happened. My girlfriend actually had a sexual affair with the married man, and she told me about it. I became very angry with her." (Why?) "Because she has a family to think of." (Is that all?) "I guess I was jealous. I felt that I couldn't trust her. I don't like to be taken for a ride. She told me a dream she had which I interpreted as meaning that she is afraid that I want a man instead of a woman."

The last statement about wanting a man instead of a woman has to be analyzed in context. It appears to represent, not a wish, but another means of controlling her girlfriend.

Thirty-sixth Session

Dream: "I steal some bicycles and try to sell them in another city."

Associations: "As a child, when I was angry with my mother, I went riding on my bicycle. That was the only escape for my anger. I felt reckless and could control almost anything by the speed with which I rode."

Dream: "I'm going to a movie and am accosted by three drunken men who want to rape me. I have a gun which I know is not loaded,

but I try to scare them by pulling the trigger, but no bullets come out. I then hit them on the head with the muzzle. A policewoman comes around and wants to search me. I become panicky because she'll find out that I'm not a man. Then this homosexual girl, who dresses in masculine clothes, and whom I dislike, comes around and this time she is dressed as a woman. She is quite effeminate, and she lets me kiss her on the neck."

Associations: "I'm reminded of my three stepfathers who I felt stood in my way of being with my mother. I used to use them, however, when I wanted to make my mother jealous. Each of these stepfathers had made sexual advances toward me, at one time or another. The other day I was wrestling for fun with this girl I like. She is very strong, but I finally won. I momentarily felt very hateful to her, and blacked out. This used to happen with my mother. Every time I had a fight with her and felt like killing her, I would have a fainting spell. As a little girl, I had the feeling that my mother liked me better as a boy. Whenever she wanted to hurt me, she would start fooling around with men in front of me and I could get her angry by fooling around with girls."

The patient is beginning to realize that the fantasy of her masculinity is only a pose. As she expresses it, "I have a gun which I know is not loaded." Yet, that pose is still necessary for her in her competition with men for the love of the mother, as well as to please the mother who, in her fantasy, wants a boy rather than a girl.

Thirty-seventh Session

Dream: "There's a young fellow I like until he steals my bicycle. I feel hurt. I insist that he return it at once. We start a search for it. Then the bicycle becomes a dog and we are looking for a certain dog. We find a good many of them, but I refuse them. I want only a certain one. In the end I find it and am very happy."

Associations: "Bicycles and dogs have always been very important to me, since my childhood. There was one fellow I was very fond of when I was about eight years old. He refused to let me use his bicycle and I stole it for a ride."

Dream: "I'm in a place which looks like a Catholic home with a group of young girls. Everyone is going to church for confession. I feel confused. You come into the room to eat your breakfast and,

after a while, I tell the other girls to go to church without me because I don't belong to a church anymore."

Associations: "I've turned against my religion. I somehow associate the church with everything bad that ever happened to me. The fact that you came down for breakfast would indicate that you lived in the same house as I did." (She blushes, and states that she is very embarrassed.)

Dream: "I have a good understanding mother. I'm very fond of her. I'm back in my home town wearing a plaid skirt instead of pants. No one is making fun of me, but I feel quite shaky."

Associations: "I met an older woman here who is like a kindly mother to me. She does things for me and I feel very relaxed in her presence. Ordinarily, I have a feeling that other women do not wish me to be a woman. In Greenwich Village, there was one blonde woman who became angry with me once when I even suggested wearing a skirt, but this woman makes me feel that it is worthwhile being a woman."

Dream: "I'm being psychoanalyzed when the girl I'm attached to rushes into the room and wants to talk to you about her own personal problems. You tell her to wait and then she notices me and is quite surprised."

Associations: "This girlfriend is actually very much opposed to my seeing you. She feels that you will wean me away from her."

There are elements in this session to indicate that the patient is beginning to differentiate between neurotic and healthier women. She even finds herself wearing a skirt without too much anxiety and can contemplate a relationship where the analyst lives in the same home with her and comes down for breakfast.

Thirty-eighth Session

Dream: "I'm trying to reach a normal life. I can see it ahead of me, but things seem to get in my way. I want to be honest, but people prevent me from being that way. I wake up very angry."

Associations: "I woke up from the dream feeling quite free, but empty inside. I've been quite hostile toward my girlfriend because of the affairs she has been having with the married man. She came to me and told me that she really didn't have an affair, but was only trying to make me jealous. I've definitely decided, however, that I wasn't going to get too involved with her any more."

(Discussion follows of her fear of getting hurt in her relationship with women.)

"Somehow I have the feeling that all women are hateful. I've become like a hermit since seeing you because I can't stand neurotic women any more. There are two friendly, well-adjusted attendants who make me feel secure. There isn't that jealousy and struggle as with other women. When I'm with them, it makes no difference to me whether they like others also, because there is no limit to their love. The neurotic women give me headaches and stand in my way of getting better. In the dream I could picture myself as a girl, but there were obstacles in the way."

In this session the patient works through a situation which undoubtedly existed in her relationship with her mother, to the effect that it is dangerous to get emotionally close to a woman because of the possibility of being hurt. Also, that sibling rivalry is only an indication of the mother's inability to love; for, the non-neurotic individual has a boundless capacity for loving. "There is enough for everyone."

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From here on, only the significant sessions will be recorded.

Forty-second Session

Dream: "I'm arguing with a man I hate. He is scheming to get my job. I am boiling mad and want to beat him up. He begins to talk to my boss in front of me and I don't trust him. I get a splitting headache and go for his throat. I want to kill him. I wake up with a bad headache."

Associations: "You notice I'm dressed in men's clothes again. I think it's all due to this girlfriend of mine. I hadn't seen her for 16 days and now she is back again. I felt better when she was away. Now I am anxious again."

Her strong need for masculinity is quite apparent in this session. After experimenting with feminine attire for a time, she suddenly gives it up because of her relationship with her girlfriend, with the feeling that, in order to gain her friend's love, she must be a man.

Fifty-second Session

Dream: "My mother is mentally sick and she is put in a hospital. She looks quite confused, lost, lonely, and like a little helpless child. I want to take care of her, but she is in a fog, and

doesn't know me. I wake up in the middle of the night crying a little."

Associations: "My feelings toward my mother have changed considerably in recent weeks. I always felt that I hated her; that, she didn't give me a break in life. However, I am beginning to see her now as an unstable individual who had her own emotional problems and that, when she treated me badly, she could not help herself. I wish I could be in a position to help her now, but I'm so sick myself that I can hardly help myself."

The recognition by the patient that her mother's rejection of her in childhood was influenced by the mother's neurotic attitudes is a step forward. As she admits in the dream, however, although her mother needs help, the dependency need on the part of the patient is so great that she cannot see herself breaking the neurotic ties to her mother.

Sixtieth Session

Dream: "A girl is trying to fire a gun. She keeps pulling at the trigger, but nothing happens. I keep telling her to load the gun, but she won't listen. I become angry at her stupidity. I tell her that it will never shoot until it's loaded. I take the rifle from her, load it, and she fires it. I'm satisfied."

Associations: "I used to have a gun and always used it in shooting at targets. The girl in the dream resembled my mother. Although my mother frequently gave the impression of being effeminate, yet, she seemed to be in competition with her husbands as well as with other men. For instance, she would shingle a roof by herself. I can't help but think that a gun represents power, and if a woman uses a gun, it puts her on an equal basis with a man. Its like having a penis."

The drive for masculinity continues. She identifies herself here with the mother in her competitive feelings with men.

Seventy-first Session

Dream: "I'm sleeping on a small couch. I feel danger and open my eyes. A tall, madman is looking down at me. I know he wants to kill me. As he grabs for my throat, I escape. I stay with a few girlfriends and feel safer with them."

Associations: "This dream reminds me of the time I was living with my aunt. She walked in her sleep and on several occasions,

she tried to choke me. She apparently hated me. Also when I was a little girl living with my grandparents, my grandfather became psychotic, and, even after he died, I had nightmares of his coming to my bed to choke me. The man in the dream reminds me a great deal of you. I'm still a little afraid of whether you may hurt me, although, realistically, I know you're helping me."

The patient is attempting to work through her competitive feelings toward men through the analyst. Her life is dominated by a fear of injury by men, who took her mother away from her, or by masculine women, such as mother, who denied her love.

Eightieth Session

Dream: "M. and her husband are living in a cottage away from all people. I go there to visit and she seems to be in the background and I am admiring her husband. I feel guilty, but I can't understand what my real feelings are."

Associations: "I liked this woman's husband a great deal, but I was afraid to show it because she was very jealous. Despite the fact that my stepfather treated me as badly as he did, I still liked him in some ways, but I was afraid of what my mother would do to me. The same situation existed with my uncle and aunt."

The patient's previous protestations that she did not care for men, that she resented them because they took her mother away from her, are apparently not entirely factual. Oedipal conflicts are more definitive now than ever before. Her need to take a man away from a woman, but fear of the woman's retaliation, play a role in this dream.

Eighty-seventh Session

The patient is beginning to express a strong desire to leave the hospital and try to adjust herself in the community. She will be leaving within the next few days.

Dream: "I'm trying to find a man's suit, but I can't get one. I'm angry and upset. I'm having sex relations with a young girl back home. I'm not satisfied because she is not passionate. I'm walking up the street toward my mother's home. All the trees are down and seem to block my way."

After these many analytical sessions, the patient still finds herself perplexed at the difficulty of finding her mother unless she is a man. She intends to leave the hospital as a girl, but is very uncertain about the future.

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The patient did leave the hospital, obtained employment in a factory and seemed to be making a satisfactory adjustment. She became acquainted with a neurotic man, and went with him to various places of amusement. She felt relatively secure with him until he began to make sexual advances toward her, and she then broke off the relationship.

Ninety-fourth Session

Dream: "A snake is attaching itself to my hands. I'm scared and try to get free from it. I hold its head away from me. Finally get tired of fighting and assume a devil-may-care attitude. I then find that I'm not so frightened, but, yet, feel sick inside thinking of it."

The patient has shown some progress in that she has been able to form some sort of a social relationship with a man. However, she still cannot tolerate sexual attitudes on the part of a man, as they indicate something frightening and dangerous. It is significant that shortly after this incident with the man, she again changed to masculine clothing and cut her hair short.

One Hundred-fifteenth Session

Dream: "My uncle is in a big parade. He tells me he left his car parked down the street and, after the parade, he wants me to take it and drive away. I'm happy over that. When I go to get it, I find my husband stealing it from me. I get boiling mad and run cursing after him. I finally catch up with him and have him cornered when he turns into a cat and I become sick to my stomach when the cat blows up and the guts spray all over me."

This dream occurred while the patient was continuing to make an effort to adjust herself outside the hospital. She was going out occasionally with men, but avoided sexual relations. She was struggling between her attitudes toward the good and bad men in her fantasy. The uncle represents the good man and, in fact, was the most favorable influence in her childhood. Her husband, on the other hand, represents the weak, therefore effeminate, man, who, like mother or cat, represents a constant source of danger and destruction.

One Hundred Twentieth Session

Dream: "I'm watching a train go by. Something large falls at my feet. It smashes open and gallons of oil fill the air. I run be-

cause I think that there may be a fire or an explosion. The oil soaks me so I take shelter where there are men working. I feel lonely and buy some food from a woman at a lunch counter. She is middle-aged and quiet."

Associations: "I am working at a factory with mostly girls. However, the boss is a man. He has been very nice to me, but I don't trust him. He hasn't made any sexual advances toward me, but the other day we were watching a parade from the factory window, with General MacArthur and his son, and he remarked to me jokingly that I could go for the general. This made me very angry and the same day I had my hair cut again. I feel so much more secure working only with women."

Dream: "I'm in a house with women and babies. There is an earthquake. This seems to be the end of all life. We are arguing which room to stay in. I want the strongest room available. I also want to be near a woman to love, but I can't quite reach her. It makes me feel lonely and anxious."

In this session the patient is continuing to make an effort to adjust as a woman, but is constantly threatened by the implication of sexuality offered by men, still considers them a threat, and wants to escape to the security of mother.

One Hundred Thirtieth Session

Dream: "The hood of a car is lifted and three men are trying to fix something inside. The world is full of bitterness and distrust. I want to trust one of the three men, who seems to be you, but the other two are very hostile. In the dream you are cheerful and friendly. I would like to be emotionally attracted to you, but instead I am attracted to other men."

This dream occurred while the patient was going out with a neurotic man who was rather sadistic toward her. Despite the fact that she intellectually recognizes the sado-masochistic character of her relationships with men, she finds it necessary to continue such relationships.

Dream: "I'm back home with my aunt and uncle. We are in a hotel room. I have a headache and feel very angry and scream at them, then run out into the street. I want to get in some kind of trouble. I see some bad men who tempt me, but I go to some girls instead. I feel all mixed up."

This is the aunt who was extremely jealous of any attention paid to the patient by the uncle so that the situation created was not only that of a competitive feeling against the man in her relationship to the woman, but also a reaction closely resembling an Oedipal situation, in which she resented the uncle in her attempt to gain the aunt.

Dream: "I feel quite peaceful until my mother comes in. We are both lying in bed. She looks at me in an angry fashion and yells, 'Why won't you love me?' I reply, 'I don't know what love is.' She becomes violent, grabs my arm and throat, wants to kill me. I become frightened and escape."

This session again emphasizes the ambivalent feelings the patient has toward her mother—feelings which have as yet not become resolved.

The patient continued visiting the analyst during her stay out of the hospital. After about five months she lost her position because there was insufficient work there, found it increasingly difficult to find employment and was forced to receive public welfare assistance. During this period, she formed a close relationship with another girl which was punctuated by repeated and frequent arguments, recriminations, and threats to break up. Although the patient found a great emotional need for the relationship, she recognized that there was little real love involved. During this period also, she continued to wear feminine clothing with some sensitivity. There was not the compulsive need to form new relationships with women that she previously had. Yet she felt helpless and impotent in forming close relationships with either women or men.

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After 10 months out of the hospital, she voluntarily returned herself.

One Hundred Fifty-fourth Session

Dream: "A fellow has a snake in his hand and points it at my face as if wanting to bite me. Before that I had friendly feelings toward him, but now I have become angry and developed a headache."

Associations: "I had a feeling in the dream that the fellow was threatening me with sex. So many men take advantage of their superior strength and their sex to insult and hurt women. There

was a male employee in the dining room where I worked whom I liked very much, but he always boasted of his affairs with women, and I had the feeling that he really did not love women, but wanted to see how many he could hurt."

In this session the patient shows a friendly attitude toward men, but is threatened by them when they show any sexual interest in her. To her, the sexual act is an enslavement of the woman by the man and, therefore, must be avoided.

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This, then, is the patient's condition at the present time. She finds the environment of the hospital protective in the sense that it offers a permissive family unit and still avoids the formation of too close or too lasting emotional relationships. She wears dresses and long hair, uses lipstick, and enjoys going to dances, although, up to this day, she has not danced with a man. She has verbalized her fear of the outside as requiring an independent existence, whereas she wants to be protected and supported by a mother substitute, that is, the hospital. However, she has not entirely closed the door on future development as she is again talking in terms of leaving the hospital in the near future and attempting to find employment. It may seen paradoxical that, in the one important limitation that she placed on analytic therapy, that is, that she not be changed to wear feminine clothes, improvement has occurred, whereas, in other spheres, the progress has not been too marked.

Discussion

This case presents a number of important considerations, not only on the subject of transvestism, but on the whole sphere of feminine psychology with its component fields of the pre-Oedipal and Oedipal phases, sado-masochism, homosexuality and many other related problems. A study of the history of this case brings out a close relationship between her insatiable drive for masculinity and her early relationship to her mother or mother substitutes. Men have played a relatively unimportant role in the formative years of this girl's life, except in situations of actual or fantasied competition. She became convinced quite early in life that a woman's role is disadvantageous and dangerous. Wasn't her mother made to suffer by a man, by being forced to have an illegitimate child, the patient? In the mother's numerous relationships with men, it was quite obvious to the little girl that a state of war

existed between the man and the woman, and it became a question as to who would dominate whom.

The mother took care to point out to her that the situation would have been much different had the patient been born a boy instead of a girl; that she could depend economically more on a boy than on a girl in later life. Being shifted from one home situation to another, all unfavorable, was quite convincing to the child that she was not wanted. She saw herself neglected by the mother for various men, which was sufficient proof for her that, in order to obtain her mother's love, she had to be a boy. Her emotional attitudes toward her mother have always been ambivalent. On the one hand, she wanted the love of her mother, and did everything possible to obtain it; on the other hand, because of past experience, she expected constant repulsion and reacted to it with hostility and rage.

Equally ambivalent have been her feelings toward men. On the one hand, she wanted the love and protection of a father figure, such as her uncle; yet, her experiences proved to her that the man is not to be depended upon, that he utilizes every display of tenderness on the part of the woman as a means of seduction and destruction, as was actually the case with her stepfathers and uncle. Furthermore, there was always a hostile mother figure to prevent her from getting too close to a man. In a compulsively repetitive manner, she started early in life to compete with men for the love of the mother, even to assuming a man's attire. She wanted to love and take care of a woman in the way that she would have preferred to have her mother behave toward her; but, because of her ambivalent feelings toward the mother, her relationship with all women had to be on a sado-masochistic level; that is, in every relationship between a man and a woman, it is always the woman who is in a precarious position. Added to the masochistic quality of her emotional life, is her feeling of guilt that she was responsible for her mother's unhappy situation, and should be punished for having hostile feelings toward her. There are reasons to believe that even the act of wearing men's clothing has a masochistic quality behind it, and, as she expressed it, "I am sticking my nose out for a punch, almost as if I were looking for ridicule and punishment and asking to be hurt." She also employs suffering as a cudgel over her mother. "My suffering hurts my mother more than it does me."

Freud, in his early writings, stressed the Oedipus complex as the core of the neurosis. It was not until late in life that he began to realize that a more important phase than the Oedipus phase, particularly in women, was a pre-Oedipal stage in which the primary attachment on the part of the child is to the mother, in the case of both sexes. In fact, he later stated,[7] "Many a woman may remain arrested at the original mother attachment and never properly achieve the change-over to men." He later also makes the significant statement that, "We shall have to retract the universality of the dictum that the Oedipus complex is the nucleus of neurosis." He properly gives credit for this new development in the psychology of women to women analysts, for they were "able to apprehend the facts with greater ease and clearness because they had the advantage of being suitable mother substitutes in the transference situation with the patients whom they were studying." This early relationship of the child with the mother is based chiefly on the child's need for support, security, food and protection, and, only indirectly, involves any erotic feelings on the part of the child for the mother. Even any outer manifestation of erotism is perhaps only a symbolization of the child's need for the closeness and the protection of the mother. It is this utter dependence of the child on the mother, in the early period of life, and the child's subsequent reaction against such dependence which creates a neurotic impasse. On the one hand, the child wants to depend completely on the mother and live in the eternal Nirvana of the intra-uterine state. On the other hand, it reacts with rage and resentment against such dependency. Such conflicts can become totally overwhelming in situations where the mother, because of her own neurotic needs, makes progressive and normal maturing on the part of the child difficult or impossible.

Brunswick,[8] in her discussion of pre-Oedipal influences upon later femininity, states, "The remarkable aspect of this case (a paranoid woman) is the total absence of the normal oedipus complex. The traumatic seduction had so fixed the patient to her first homosexual love object, that all further development was blocked. The poverty of psychic growth produced a simple, childlike individual in whom pre-oedipal attitudes and mechanisms, normally over-shadowed by the complications of the oedipus complex, were outstanding."

A study of the present case indicates that here, too, pre-Oedipal factors play a very important role and that the Oedipus complex is either absent, or present in only an incomplete state. The author is of the opinion that a similar situation exists in the analysis of a great many women, particularly in very dependent, passive, immature individuals, as well as in schizoid and schizophrenic subjects.

The question comes up as to the relationship of female transvestism to homosexuality. This would depend a great deal on our concept of homosexuality.

Kinsey[9] states, "In view of the data which we now have on the incidence and frequency of the homosexual and, in particular, on its co-existence with the heterosexual in the lives of a considerable portion of the male population, it is difficult to maintain the view that psycho-sexual reactions between individuals of the same sex are rare, and therefore abnormal or unnatural, or, that they constitute within themselves evidence of neurosis or even psychosis. If homosexual activity persists on as large a scale as it does, in the face of the very considerable public sentiment against it, and, in spite of the severity of the penalties that our Anglo-American culture has placed upon it through the centuries, there seems some reason for believing that such activity would appear in the histories of a much larger portion of the population if there were no social restraints. The very general occurrence of homosexuality in ancient Greece, and its wide occurrence today in some cultures in which such activity is not as taboo as it is in our own, suggests that the capacity of an individual to respond erotically to any sort of stimulus, whether it is provided by another person of the same or of the opposite sex, is basic in the species."

Psychoanalysts will readily recognize the fallacy of such reasoning, for it might be equally used to prove that neurosis is normal, inasmuch as it occurs in such a large proportion of the population. It is probably true that, were it not for social and cultural restrictions, there would be a greater number of overt homosexuals, but it is also probable that, even under circumstances where permissive attitudes existed, individuals practising homosexuality would still be responding to neurotic needs.

The work of Ford and Beach[10] would indicate the occurrence of homosexual activity in subhuman species, but their findings are not conclusive. It would appear that, although such activity does exist

in lower animals, it frequently is an indication of immaturity or is a result of frustration in heterosexual drives, although the authors themselves appear to consider it a normal activity in some stages of the development of the animal.

Deutsch[11] states, "The view that female homosexuality is in the overwhelming majority of cases psychologically determined, is supported by the fact that a great number of women whose sexual love objects are of the same sex do not give the impression that their physiologic characteristics have undergone changes in the direction of masculinity." Again, "Her homosexuality expressed not the existence of an organically determined urge, but an emotional need to love and at the same time to avoid her inferiority as a woman." Yet, in the very same manuscript, she says, "It is certain that normally puberty includes a phase in which the sexual drive is directed more or less toward both sexes."

At the risk of oversimplification, the following represents essentially the views of Freud and many of his followers on the subject: We are all basically bisexual. This is demonstrated by the remnants of both sexes in our biological make-up; and by the fact that we go through a period in life when we are normally predominantly homosexual in object choice. Normally, as we reach the genital phase of development, we repress our homosexual tendencies and assume a heterosexual existence. In all normal people, unconscious homosexual strivings can be discovered. In some people, whether for psychological, environmental or biological reasons, the individual is unable to repress these homosexual tendencies successfully; and, instead of remaining latent and repressed, they become overt, or precipitate a neurosis. Freud distinguishes between the individual who is able to repress his homosexual tendencies from the one who becomes overtly homosexual, the latter being difficult or nearly impossible to treat effectively with psychoanalysis. This distinction becomes somewhat difficult to comprehend, when it is further pointed out that one of the important areas of conflict of the psychoneurotic involves the attempt on the part of the individual to keep repressed homosexual drives from becoming overt. Freud, apparently, places the overt homosexual in a class by himself; and, either by actual statement or implication, assumes an organic basis for the condition. Yet, in another place, a letter from Freud[12] to the mother of a homosexual son, he states that homosexuality cannot be considered as an illness.

The Freudian concept of homosexuality implies, therefore, that it constitutes a basic conflict against which defenses have to be created; that, if defenses are inadequately created, it constitutes a neurosis, and, if defenses are not at all created, it is not a neurosis and, in fact, is not even an illness. This is paradoxical, to say the least. It also implies a biological capacity on the part of all of us to show erotic feelings, which are not neurotic in character, toward members of the same sex.

It is questionable whether the foregoing concept is consistent with present-day experiences in dealing with homosexual patients. The author is of the opinion that what is referred to as homosexuality, is only a symptom in a neurotic structure. He holds that, in fact, homosexuality cannot exist without neurosis, which is contrary to the original Freudian view that the neurosis is a defense against homosexuality. This may appear to be an unimportant quibble over terms; but it actually constitutes a basic difference in attitudes, for it sets up the proposition that the homosexual striving is not a primary conflict, but is secondary to neurotic needs. It makes a great difference in the ultimate handling of a patient whether the analysis reveals a basic conflict over homosexuality as the cause of neurosis, or, whether the apparent homosexuality is only an indication of underlying conflicts involving significant people in the patient's past life.

In the present patient, her attraction to women, that is, her homosexuality, is overdetermined. It is first, a means of regaining the love of the mother; second, a way of making the mother jealous; third, neurotic domination of the mother, or mother figure, which she was helpless to accomplish as a little girl; fourth, masochistic submission to the mother figure as a re-living of earlier experiences, as well as through feelings of guilt. Fifth, it is a defense against the mother's aggression on the assumption that one can neutralize an enemy best by being in close contact with him. Sixth, on an Oedipal level, this patient's homosexuality is the removal of the antagonist from the heterosexual love object. The writer asked a little girl why she insisted on having her mother sleep with her. She replied promptly, "I don't want her to sleep with my daddy." Other determinants are, undoubtedly, present. However, in no instance, does love, in the sense of tenderness, play an important role in this girl's relationship with other women. In fact, homosexuality is inconsistent with love.

Female transvestism, therefore, is not a manifestation of homosexuality but of a drive for masculinity. Qualitatively, it does not differ essentially from other similarly-motivated disturbances in the sphere of feminine psychology. The supposedly happily-married woman who is eternally competing with her husband is the more subtle prototype of the same problem. Homosexuality has no meaning except as a multi-determined manifestation of neurosis.

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A METHOD OF EVALUATING PROGRESS IN PATIENTS SUFFERING FROM CHRONIC SCHIZOPHRENIA

BY D. H. MILLER, M. B.; J. CLANCY, M. B., AND E. CUMMING, M. A.

It is difficult to evaluate the results of therapy in chronic schizophrenic illness owing to the nature of the disease process and the possible variables which affect it. Close study of individual patients has often been made during psychotherapy, for example by Rosen,[1] but in mass evaluations of chronically ill schizophrenics the tendency has been to class patients as "improved" on the basis of their ability to make certain adjustments within the hospital sub-culture or in society outside. It is seldom stated whether a patient is making a social adjustment within the confines of his illness or whether there has been a modification of the psychotic process.

An attempt has been made in this paper to evaluate within a hospital* the factors which may affect the illness by close observation of a randomized population in as controlled a manner as possible, in conditions which vary only within certain limits. Patients were observed by nursing staff and physicians and results were recorded, progress being evaluated from these reports. From the nature of the illness it was felt that the patient's own evaluation of his state was not meaningful, because of the difficulties of communication, and the fact that the patients studied had been ill for an average period of 10 years. The minimum duration of hospitalization was three years, the maximum 23. During this time, patients became conditioned to live as comfortably as possible within the confines of their psychotic illness, and they could give no "real" meaning to the words "well" and "unwell." From observation, it would appear that patients try to reach a state of equilibrium with their illness, a state which depends either upon relative inertia or stereotyped forms of activity. For example, take one patient who spent much of his time pacing the washroom. When another patient crossed his regular path he became disturbed, immediately moved from his usual path and, on inquiry, said that he felt "gashed."**

*Saskatchewan Hospital, Weyburn, Sask., Canada.

**This example was produced by Jules Henry, Ph.D., associate professor of anthropology at Washington University, St. Louis.

It was felt that it was important to try to assess a patient's social performance within the hospital ward independently of the assessment of his psychotic state. The justification for this dichotomous approach is that in certain cultures schizophrenics appear to be tolerated or encouraged by the societies in which they live and—after the acute phase of illness is over—are able to function at a high level of performance socially.[2, 3] It would seem from the description by anthropologists that these schizophrenics are suffering from what would appear to be a crippling psychosis in our culture. It appears likely that the inter-relationship of a schizophrenic with his environment depends to some extent upon the environment as well as upon the nature of his illness. If this is so, performance might change independently of any observed change in the psychotic state. To this end two parallel series of assessments were carried out, one by at least four nursing staff members independently of each other and of the authors, and one by two of the authors, (D. M. and J. C.) and two other physicians who were asked to define the patient's clinical status at intervals.

The latter two received no indication as to the location of the patient's environment or as to what treatment, if any, the patient was receiving. It would thus be possible to assess how much the foreknowledge of the patient's status by a physician affected his ability to make an impartial assessment. The authors, who were closely bound up with the patient's welfare and concerned with the progress of the investigation, might, it was felt, produce an evaluation which was not reliable. The method was also designed to study the effects of environment on social behavior and psychotic illness in chronic schizophrenics and to assess what difference environmental manipulation in the form of specific therapy might make. As observations were taking place continually, it was also felt that it might be possible to observe the way symptoms might fluctuate in a very chronic illness and also observe whether environmental manipulation affected this fluctuation. It would also be possible to judge whether, within the confines of his illness, there might be variations of a patient's social performance. All the patients studied had failed to respond to one of the following treatments or a combination during their stay in hospital: insulin, ECT, metrazol and hydrotherapy. None of the patients had received treatment for at least one year preceding this study. The average age of the patients was 35. All had been diagnosed on

first admission as schizophrenia, catatonic type; but, on studying their records, it was obvious that many, from time to time, had presented features suggestive of paranoid illness, hebephrenia and simple schizophrenia.

Material and Method

Fifty male patients were selected at random from the Saskatchewan Hospital population of long-stay patients diagnosed on first admission as catatonic schizophrenia. Ten of these were further selected, and no change in their usual routine was effected, save a series of interviews with the assessing psychiatrists at intervals of two weeks.

The remaining 40 patients were moved to a new environment, designed to promote a high level of activity among the patients, and 10 more were randomized out as controls. The remaining 30 patients were thus available for special therapies under controlled conditions in randomized groups of 10. The specific therapies initially tested were ECT;[4] non-convulsive electric shock stimulation, with pentothal;[5] and pentothal alone.

These 40 patients were assessed on alternate days by the nursing staff on special forms for the purpose. The 10 controls, left behind in their old environment, could not be so observed, as it was felt that an uncontrolled variable would be introduced because they tended to be in wards with a standard of overcrowding which would make inconspicuous observation impossible. Once a nursing staff member had made his assessment it was handed to the ward supervisor and not made available to the evaluator again. Staff members were asked not to discuss their evaluations with each other.

The patients were grouped together in the ratio of one staff member to eight patients, on the basis of group assignment as devised by McKerracher.[6] The total period of observation recorded in this paper is eight weeks; and during that time, owing to the shift system at work in the hospital, each group was observed by at least four nursing staff members, two per day, who made individual assessments on the patients. Unless there was agreement between the staff members, their observations were discounted in the final assessment. This was possible because each patient was reported on 56 times. The assignment of staff members to patients was a random affair, and no attempt was made to place a

particularly good nurse in charge of a difficult patient. The staff members were asked to make a series of observations on the patients which covered the following points: the type of occupation carried on by the patient, his level of verbalization, whether he was neat and tidy, what help was needed for washing and shaving, and his toilet and eating habits. In addition the observers noted his ease of handling, particularly in relationship to whether they felt he was interested in his environment. Separate records were kept by the ward supervisor which recorded the incidence of any particular disturbance. No sedative drugs were given to the patients, and a record of breakages and clothing damage was kept.

These forms, filled in by the staff members were assessed by the two medical authors at four separate time intervals, each covering a five-day period. It was thus possible to give positive answers to the questions that are shown in Table 1. Any increase or decrease in the number of patients showing these qualities could then be assessed as to the statistical significance of the change. The method used to test differences was chi-square with the

Table 1. Categories Studied for Social Performance

No. of patients actively occupied. (Games, O. T.)	No. of patients passively occupied. (Cinema, shows, etc.)	No. of patients answering questions.	No. of patients clean and tidy.
No. of patients able to wash and shave without help.	No. of patients continent of urine.	No. of patients continent of feces	No. of patients who, staff felt, showed an interest in their environment.

Yates correction.[7] It is then possible to compare any treatment group to itself and to a control before and after receiving specific therapy. Comparisons for all criteria were made; and, whenever the difference was significant, this is recorded.

The environment was so designed as to afford ease of observation of the patients' activity and social behavior by the staff members concerned. It is discussed more fully by the authors elsewhere.[8]

Assessments of the patients' psychotic states were performed by three units of physicians at intervals of two weeks. Unit 1 consisted of two of the authors, Units 2 and 3 of physicians working independently. Unit 1 did not assess the control group left behind in

its old environment as it was felt that it was wise to disturb these patients as little as possible. These assessments were conducted in offices away from the treatment ward.

These physicians assessed the patient on the following factors: (1) his level of activity in the interviewing situation; (2) his appearance both as to general cleanliness and appropriateness of expression; (3) his responsiveness to the examiner's interviewing technique; (4) his mood—whether affect was preserved, whether it was present but unusual or inappropriate or where there was no obvious affect; (5) speech—whether diction was well outlined and spontaneous or in what way it was abnormal; (6) whether hallucinations were present; and (7) whether waxy flexibility could be elicited.

The last two qualities are dichotomous, but it is theoretically possible on a statistical basis to assess the first five into an intensity scale. It was decided to assess each of these qualities for the sake of simplicity on a grading of A, B, C, in which A can be considered to be the most nearly normal, C the most abnormal. The physicians doing the assessing did not in fact score the patients. All the assessments were collected together; and the remarks made as to each quality were independently analyzed and graded on the three-point scale. Although there is obviously some semantic difficulty, it was possible to arrange the remarks into three categories, A, B, C, as just noted, and then give each comment a rating score. Table 2 is an example of how this was done for responsiveness, but similar tables were made for all the qualities assessed except the last two, which were either positive or negative.

Table 2

(A)

1. *Appropriate verbal response*	2. *Appropriate Environmental Response*
Obeys commands	Friendly
Constructive conversation	Leaves briskly
Spontaneous conversation	Effort to introduce himself
Uses decisive words	Holds out hand to be shaken
Gives an account of himself	In touch with surroundings
Initiates a conversation	Accepts proffered hand
Expresses preferences	Good attention
Speedy, appropriate response	Looks alert
Expresses an opinion	Good memory

(B)

1. *Retarded Verbal Response*	(2) *Retardation of Action*	(3) *Inadequate Response to Environment*	(4) *Partial Disorientation*
Speaks when spoken to	Leaves slowly when asked	Orders examiner about	Disorientated in some spheres
Able to carry on conversation	Tries to make contact	Will hold hand —no grip	
Fairly responsive to questioning	Can carry out a simple command		
Answers questions with persuasion	Aware of surroundings but has difficulty in interpreting them		
Delayed response to questions	Obeys commands reluctantly		
Distant response	Willing to cooperate		
Vague response to questions			
Responds in another language			
Shy answers			
Answers simple questions, will not answer more complicated ones			
Shows interest in some subjects			

(C)

1. *No Response—Verbal*	2. *No Response—Environmental*	3. *Inappropriate Response to Questions and Environment*
No verbal response	Limbs in same position	Inappropriate response to questions
Aware, but no response	Requires to be pushed through door	Same response to all questions
Doesn't answer questions	Does not obey commands	"I don't know," to all questions
Self-absorbed	Ignores surroundings	Incoherent and unintelligible
Understands questions, but does not reply	No reply to greeting	Mumbles with or without questioning
Ignores questions	Resists attempts to move him	Silly laughing response
Preoccupied with something else	Listens without replying	Smiles in reply to questions
	Inaccessible	Does not follow objects with his eyes
		"Snakes hands"
		Picks up objects
		Stuffs things in his mouth
		Disinterested
		Seclusive
		Resistive to attention
		Impulsive
		Blocking
		Restless
		Bizarre movements
		Answers on a delusional basis

4. *Disorientation*	5. *Stereopathy*	6. *Negativism—Automatic Obedience*	7. *Echopraxia*
Disoriented in all spheres	Stereopathy	Negativism Automatic obedience Attempts to write, but without result	Echopraxia

Results

The assessments made by the three units of physicians were analyzed for consistent agreement, and all 50 patients initially randomized were studied. With 50 patients being rated for seven items, there are 350 possible points of agreement. This agreement is as listed in Table 3.

In assessments 2 and 3, Unit 1 did not assess the controls, and the figures shown represent a correction for 50 patients.

Table 3. Agreement Between Doctors Over 350 Possible Points

	Assessment 1	Assessment 2	Assessment 3	Assessment 4
Units 1 and 2 agree.....	203	213*	265*	203
Units 1 and 3 agree	201	200*	280*	217
Units 2 and 3 agree	230	213	215	222
All units agree	149	143*	211*	152

*Unit 1 represents the authors. In assessments 2 and 3, they did not assess the controls, and the figures marked with the asterisk represent a correction for 50 patients.

The average agreement among all three units is more than 10 times as great as would be expected by chance alone. There is no significant trend toward greater or lesser agreement over the four assessments, although assessment 3 shows the highest concordance.

If the prior knowledge of the patients' treatment was to affect the assessment of Unit 1, it might be expected that there would be a trend away from agreement with the other units. It is obvious from the table that this did not happen, and it would appear that knowledge of the patients' treatment does not necessarily affect the clinical judgment of a patient that a doctor might make. It is clear that the presence of independent assessors must influence the degree of detachment of the doctors who carried out treatment, and this, therefore, need not mean that only one series of assessments should be made. The level of agreement shown by the various units is a maximum of 60 per cent, a minimum of 40 per cent. A psychiatric assessment is essentially subjective on the part of

the examining physician, and the lowest concordance was obtained on the assessment of a patient's appearance, which was on the whole constant throughout the examination day, although there might be some change as to the growth of a patient's beard and his appearance before and after meals. Since patients were presented to the examining physicians in a random order, this should

Table 4. Comparison of Agreement (Crude Figures) on Appearance and Mood of 50 Patients

	Assessment 1		Assessment 2		Assessment 3		Assessment 4	
	Appearance	Mood	Appearance	Mood	Appearance	Mood	Appearance	Mood
Units 1 and 2 agree	18	31	19*	34*	17*	36*	27	35
Units 1 and 3 agree	24	35	17*	34*	27*	39*	24	36
Units 2 and 3 agree	22	42	19	37	27	34	28	33
All units agree	11	28	8*	26*	15*	27*	16	27

*Figures corrected for 50 patients

not have significantly affected the results. It will be seen from Table 4 that it was apparently much more difficult to obtain agreement on the appearance of a patient than on his mood; and yet it would have seemed likely that the latter was a much more subjective assessment.

In the scoring of patients, the lower score was used throughout whenever there was disagreement—on the assumption that the patient cannot, for example, be considered free of hallucinations if one of the assessing units distinguishes hallucinations. It is recognized that a patient who commonly hallucinates may, on any one day, appear free of hallucinations, and vice versa, but the chance of this happening is constant for all patients. In other words, the chance of a patient being observed, on assessment, to hallucinate, is a direct function of the frequency of his hallucinations and, therefore, over the whole group, other factors being constant, the relative proportion of hallucinating patients observed should be constant from assessment to assessment, unless there is a change in the psychotic state. Differences among the five groups of 10 patients were analyzed for each of the seven factors on each assessment.

It was found that the control groups shifted markedly from assessment to assessment, that is, both those for whom the environment was changed and those who were not moved from their usual

routine. This can be demonstrated if the two dichotomous factors of those hallucinating and those showing waxy flexibility are considered. In the control group whose members were not moved to the treatment ward the number found to be hallucinating varied from four to eight over the period of the assessments. This is a significant change. The number found to be hallucinating in the new environment varied from one to seven, which is again significant. Flexibility varied in the two groups from four to seven and four to six which is not significant. It is impossible to make a before-and-after comparison with this small group as it would appear that any differences in the psychosis might easily be part of the swing of disease. One cannot assume then that a new environment in which activity of the patient is stressed affects the patient's psychotic symptoms. If this swing in symptoms is considered to be operating independently of the experimental situation, it is possible to compare all the various groups on each assessment made. However, if the total of 30 patients who had received the various forms of treatment were compared to the total control group of 20, considering together those receiving no specific treatment, one suggestive difference emerges which is shown in Table 5 with a chi-square value corresponding to a probability of chance distribution of less than 5 per cent. The whole population tended to have progressively more hallucinations over the experimental period of two months, but the group receiving treatments of various types have, suggestively, more hallucinations by the fourth assessment. Since chi-square is on the borderline of significance, this observation may be worth repetition.

Table 5

	Assessment 1		Assessment 2		Assessment 3		Assessment 4	
	Treated	Control	Treated	Control	Treated	Control	Treated	Control
Hallucinating	20	10	26	14	27	18	30	17
Not hallucinating	10	10	4	6	3	2	0	3

Chi-square = 4.904911. Probability of chance distribution = .03.

It has already been stated that no estimate of social performance was made on the control group not moved; and, therefore, in studying the effects of environment, one must compare the control group on the active treatment ward to itself, on the basis of any difference between performance on arrival on the ward and performance at the end of the eight-week period. One can also see whether the

groups receiving treatment perform better than groups not receiving such treatment. Elsewhere the authors have compared the effects of each treatment and compared them to each other.[9]

Table 6 gives the performance figures for the group receiving treatment and the group acting as controls. It will be seen that there was an improvement in performance on all items studied for both groups; but, insofar as the control group was concerned, although the differences are suggestive, only the fact that all members became continent of feces is significant. As the patients were randomized, it is a chance finding that the treatment group mem-

Table 6

	No. actively occupied	No. passively occupied	No. answering questions	No. not helped to wash and shave	No. clean and tidy	No. clean, urine	No. clean, feces	No. showing interest in environment
Treatment Group								
On arrival on ward	12	20	13	11	15	21	27	1
After 8 weeks	28*	28*	18	18	19	22	30	13*
Control Group								
On arrival on ward	5	6	3	4	5	1	5	1
After 8 weeks	6	7	5	6	7	4	10	4

*Figures are statistically significant.

bers were significantly more continent of feces initially than the control group. Insofar as the treatment group patients are concerned, they show significant improvement in their level of activity, both active and passive, and also in the number the staff felt showed an interest in their environment.

For those actively engaged in doing something, there is a net gain for the treatment group relative to the control group which is highly significant as chi-square=13.871409 and the probability of this being due to chance is very much less than 1 per cent. For those attending at entertainments of various types chi-square=4.658385; the probability of chance lies between the 5 and 1 per cent level. For those showing interest in environment, the treatment group is significantly more interested at the end than at the beginning, but there is no significant net gain over the control group, which in itself shows a gain which is not significant. Since all groups showed a steady increase in hallucinations, it would thus

seem that—while social performance is, in general, improving—the disease itself appears to become more acute. The relationship between the two is well shown if the performance of one of the patients is considered. It is felt that with this type of handling of the patients there may well be a breaking point, if a patient is pushed too hard; and, in this case, he will likely lose complete touch with his environment. An illustrative case follows:

The patient was a man of 44 who had been hospitalized with a diagnosis of catatonic schizophrenia since 1933. He was usually mute before admission to the special ward but was reported to have outbursts of catatonic excitement at about two-month intervals, when he became incontinent and unmanageable. When the patient arrived on the ward he was reported to be mute, untidy, seclusive, refusing all types of activity, dirty and incontinent of urine. Within seven days, he was reported as engaging in full activities, answering questions, talking to other patients, being neat and tidy and co-operative and helpful. The staff became very enthusiastic about his progress and tended to push him to even greater levels of activity. On the eighth day, he became acutely disturbed and restless, and this behavior lasted for a two-day period. At this point, the whole pattern was repeated, but, on this occasion, the improvement lasted 10 days. The patient then became disturbed for a two-day period again and then was well and active for five days. Again he became restless and aggressive until, on his next improvement, the staff was instructed to be a great deal more permissive and to allow him to go at his own pace. From that time on, his social performance remained at a high level; he was clean, active and verbalized to some extent. On clinical examination at the end of a four-month period, he still showed clinical signs of catatonia, but his disturbances appeared to have ceased.

Within the limits of this patient's illness, there is a range of social performance; and a relationship between environmental pressure and acute flare-ups of his psychosis is demonstrated. Since all the patients concerned began to hallucinate more obviously; it would appear that an improvement in environment, with more activity on the part of the patient, if not geared to the needs of the individual, may again lead to an acute breakdown and withdrawal from reality. If, however, the environment within the hospital is sufficiently well designed so as not to threaten the patients, they

are capable of an increase in performance without a change in the observed state of psychosis. This is borne out by the fact that the psychotic state of the control group on the active treatment ward did not change relative to the control group off the ward; and in the latter's case, there was no reason to assume that there had been any change in social performance.

Summary and Conclusions

Anthropological investigations appear to justify a dichotomous approach in the study of chronic schizophrenics.

A method has been devised wherein it has been possible to assess the social performance and clinical status of a chronic schizophrenic in an active treatment ward. This assessment has then been submitted to an assay of statistical significance by the chi-square method.

Selection of patients was on the basis of randomization; and, thus, it was possible to discount many variables, as complete control of a patient or his environment is not possible. It is shown that knowledge of the patient's treatment and environment does not necessarily affect the ability of the physician to make an impartial clinical assessment as to a patient's progress. The subjectivity of this assessment is, however, demonstrated—in that it is most difficult to obtain agreement on a description of the patient's appearance. However, despite this, the concordance obtained was 10 times greater than chance would dictate.

The variation in symptomatology in chronic schizophrenia has been shown; but, despite this, certain trends were demonstrated by the method described in this paper.

If the following groups of patients are considered, a control group in an environment usual for it, a control group in an active treatment environment, and a treatment group in such an environment, the following factors emerge:

There is no difference between the clinical status of the two control groups.

The treatment group members, taken as a whole, show suggestively more hallucinations than the control group. The authors have discussed elsewhere,[9] the individual treatments given and have shown that they do not differ in their effects.

The number of patients showing better social performance increased for all groups on the active treatment ward. As regards

their activity level and the interest that the staff felt they showed in their environment, this increase was of statistical significance only for the treatment groups taken as a whole.

In a single case, the relationship between environmental pressure and acute disturbance during chronic breakdown is demonstrated. This can be avoided by suitable manipulation of the patient's surroundings. It would appear from the over-all results that this relationship might be general in all cases undergoing active treatment.

Within the limitation that acute breakdown may be precipitated by the hospital environment, the dichotomous approach to the study of a chronic schizophrenic reveals that a wide range of social performance is possible, and that this is to some extent independent of the observed clinical state of the patient. Performance increased most significantly in the treatment group members, and, in their case, the illness became more acutely evident, as shown by the observation that there was a suggestive increase in the number of patients exhibiting hallucinations.

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OBESITY: AN ETIOLOGIC STUDY*

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The gravity of extra poundage cannot be overemphasized. The obese may be popularly accepted as healthy or even envied as "fat and jolly," but can only be classified as most unfortunate, when the tremendous increase in incidence of cardiovascular disease, digestive disorders, joint pains, accidents and even suicides are considered. Obesity has been divided into the endogenous and exogenous types. In the former, the acquisition of fat is traced to a primary decrease in body metabolism due to an endocrine dysfunction. Although these cases are of great interest and are frequently reported in the literature, they form a very small portion of patients (3 per cent in Silver and Bauer's large group.)[1] In the exogenous type, emphasis is merely shifted from decreased expenditure to increased intake. Actually all obesity is alimentary; there is only one aperture by which such matter gets under the skin, the mouth.

The question of why people become obese, i. e., why some individuals ingest amounts of food in excess of their needs, was the subject of a joint investigation by the endocrine, anthropological, psychiatric, and social service departments of Jefferson Medical College, Philadelphia. To reduce the variables, the initial group was limited to obese white females, of whom 103 are here reported. Patients with hypothyroidism and others in whom obesity might be secondary were excluded. Some of these patients sought medical consultation primarily because of concern over their weight; others had various other complaints and were referred to the research group. Their inclusion in this group, however, indicates enough interest on their part so that they returned for the various studies. Unfortunately, but not unexpectedly, a number, upon learning the doctors did not have a magic cure, failed to make the repeated visits which would have been necessary for adequate psychiatric evaluation. However, even in these cases, the psychiatric

*This paper reports the results of a study made at the Curtis Clinic and Daniel Baugh Institute of Anatomy of the Jefferson Medical College, Philadelphia. The patients were studied from medical and endocrine standpoints by Dr. Karl E. Paschkis, anthropologically by J. Lawrence Angel, psychiatrically by Drs. Robert R. Schopbach, Albert Kaplan, and Robert A. Matthews. Dr. Paul Swenson collaborated in radiologic studies, and Olive J. Morgan, Ph.D., carried out the psychologic tests. For advice and criticism, the writers are deeply indebted to Dr. Karl E. Paschkis.

material, plus information obtained by the other departments, especially those of social service and anthropology, permits some conjectures. The fact that only one patient availed herself of prolonged therapy (q. v.) indicates the common lack of any sincere desire to curb overeating.

A. *Anthropologic Factors*

The hereditary factor in obesity has always been stressed. Rony[2] observed that regional lipophilia was a family trait often shared by parent and offspring and that identical twins had the same type of fat distribution although they might be of quite different weights. The steatopygea of Bushman women is a racial characteristic. The familial incidence of obesity in the present study is presented in Table 1. While it must be remembered that these families are selected by having at least one fat daughter, the occurrence of almost 40 per cent of obese offspring from average parents, over 50 per cent in mixed matings, and over 60 per cent

Table 1. Genetic Background in Obesity; Based on Descriptions by 98 Adult and 18 Adolescent Philadelphia Obese White Females

Type of mating		Offspring		Sons			Daughters (incl. subjects)			Offspring
Father	Mother	No.	Per cent	Total	No.	Obese	Per cent obese	No.	Obese	Per cent obese	Per cent obese
Fat	× Fat	30	25.9	130	57	32	56.1	73	51	69.9	63.9
Fat	× Avg.	18	15.5	70	32	13	40.6	38	27	71.0	57.1
Avg.	× Fat	42	36.2	210	87	33	37.9	123	69	56.1	48.6
Avg.	× Avg.	26	22.2	128	51	8	15.7	77	40	52.0	37.5

in fat × fat matings indicates some kind of segregation. Normally about 9 per cent of the offspring of average matings may be expected to become obese.[3] Even this percentage would probably be reduced after allowing for psychosomatic effects. Thus the likelihood of simple recessive genetic determinants is very poor. The data also do not fit any such simple hypothesis as two-gene dominant causation but indicate that a number of genes must be involved.

Anthropological studies strengthened this concept of a hereditary factor. On the whole, the present data indicated a retention of slightly juvenile proportions and morphologic traits, especially in the extreme endomorphs. Over a quarter of the group exhibited a particular excess of the "juvenile" fat pattern and a lack of

feminine body traits, with a tendency as much in the direction of the infantile as of the male. The menarche at 13.35 years indicates maturation slightly ahead of normal for the environment. The menarche at 13.0 years for those obese from childhood onward is even more suggestive of early maturation. Bruch[4] stresses that early-maturing children tend to be taller and bigger than their peers before puberty but also cease growing before those maturing at the usual age. Other things being equal these early-maturers should tend in adulthood to be shorter and stockier and to retain juvenile body proportions, since, as compared with the average, a greater proportion of their growth took place during childhood.

Furthermore, those who remain fat from childhood up, differ in body type from those who become fat only after pregnancy. Thirty-three subjects, fat from childhood, had an average somatotype of 6.0—2.9—1.4 which was slightly more endomorphic than the total group. Thirty-four becoming fat after pregnancy averaged 5.5—3.1—1.6 or slightly more mesomorphic than the total whose average was 5.83—2.88—1.50.[5]

A comparison of body builds between the 31 subjects who managed to lose 25 pounds or more at one time or another and those who did not do so revealed so slight a tendency of the former group toward mesomorphy as to be meaningless. The obese are not genetically uniform, but it appears that genetic factors do not directly determine the ability to lose weight.

B. *Neurologic Factors*

The urge for food intake depends on stimuli from many portions of the nervous system. Physiologic hunger is produced by contractions of the empty stomach and other portions of the intestines, since hunger is felt even after bilateral vagotomy and complete gastrectomy. The paths via the vagi and vagal nuclei of the medulla to the thalamus are fairly clearly worked out. Experimental evidence,[6] however, indicates that the cortex, subcortex (especially the frontal lobes), and hypothalamus are most important in the production of appetite. Increased food intake and weight gain is of frequent occurrence after bilateral prefrontal leukotomy but is much less frequent after unilateral section.[7] This frontal area is an important cortical center for emotional stimuli. Long, et al.,[8] in their excellent work on hypothalamic obesity concluded that such lesions produced obesity as a consequence of increased appetite

rather than of any metabolic disturbance. When his animals were pair-fed, only one of 10 operated animals outgained its controls.

Wilder[9] thinks variations in the activity of diencephalic centers may well be hereditary in origin, and feels that the resulting changes in appetite explain familial obesity better than the cultivation of faulty eating habits. Bauer[10] argued the exaggerated viewpoint that, were obesity non-hereditary, all offspring of a fat × fat mating should be obese. Actually it is true that should genetic factors play no part in the determination of the potentially obese, there would be fewer fat offspring of thin parents and many more fat offspring of obese parents. If hereditary factors are involved, they may sensitize the hypothalamus toward increased appetite in its response to fronto-thalamic emotional stimuli and visceral contractions, initiated by anxiety, hostility, or resentment. (The fact that similar psychic disturbances are reported to produce both ulcers and obesity becomes more comprehensible when the differences in hereditary anlage as exemplified by body build are considered. The person developing ulcers does not have the inherent potentialities for obesity.)

C. *Psychologic Correlations*

Psychologically it becomes important to note what stresses precipitate excessive appetites in these sensitized individuals. Only 10 per cent of the patients studied were considered to fall within the limits of emotional normality. The remainder gave evidence of one or more long-standing disturbances varying from paranoid schizophrenia, hypochondriasis, and hysteria to prolonged enuresis, nail-biting, and distressing anxiety. This incidence and variety of clinical pictures has been reported elsewhere,[11, 12] but it is even more significant here since the writers' subjects were not primarily psychiatric patients. It is also possible that, had more complete study been possible, more psychopathology would have been recognized.

These subjects had suffered more than average stress as children. In about a quarter of the families, one or both of the parents had died during the childhood of the patients; and 16 per cent suffered deprivation through poverty. In 15 per cent, the parents were considered to have been excessively strict, but in almost an equal number the parents were overly solicitous. The family life of these individuals was further distorted by about a quarter of

the parents being separated or divorced and another quarter living together amidst constant friction. Only about one-quarter of the patients can be said to have had fairly normal healthy family lives. Marriage, as an escape from such unpleasant, unrewarding situations, frequently led to even more unsatisfactory relationships and may account for the high number of marriage failures. Out of 68 subjects only four described their relations with their husbands as good. Twenty-two described theirs as "average"; 18, as fair; and 24, as poor or very poor. Half complained of definitely unsatisfactory sexual adjustments and only a very few claimed real satisfaction. In over a third of the cases, pregnancy served as the precipitating factor for weight gains while in even a larger number a distinct aversion toward pregnancy was stressed (Table 2). It is also noted that marriage, often unsatisfactory, and menstrual changes (menarche and menopause) initiated the overeating of another 10 per cent, so that in about half of all cases, there was a very close relationship between psychosexual matters and the onset of obesity.

Table 2. Precipitating Factors

Factor	No. patients
Menarche	4
Marriage	6
Pregnancy	35
Loss of love object (parent or husband)	12
Operation or illness	8
Change of occupation	6
Miscellaneous (rejection, constant frustration, acute psychic trauma, etc.)	11
None discovered	21
Total	103

The fact that obesity is more frequent and more pronounced in females[13] and becomes more common in older age groups (except in the aged where the increased mortality has already claimed the obese) might be explained by the greater number of psychosexual problems encountered by the female than by the male and by the additive effects of life's stresses.

In studies by Bruch,[14-17] about 70 per cent of the obese children studied were the youngest or only children. Often the father was found to be weak and submissive and unable to give positive guidance to the child. At the same time the mothers displayed overt

solicitude and overprotectiveness in an attempt to conceal underlying rejection and resentment. In such an environment, which does not offer sufficient emotional satisfaction, food gains inordinate importance; it is offered and received not only for the appeasement of a bodily need but becomes highly charged with emotional values. This corresponds to the primary type of obesity of Rascovsky, et al.,[18] in which maternal solicitude excessively satisfies the infantile oral demands, destroying by anticipation the need for the organism to investigate the environment further. The ego becomes "fixed" at a preambivalent stage of orality, unable to handle daily frustrations of later life without undue tension and hostility. In the present writers' group the birth order showed no deviation from normal expectancy with six being only children and 21 being youngest. Absence of the father as an important figure and overemphasis of food as a symbol of love were, however, present in a number of cases.

Frequently the girl had remained of approximately normal weight until leaving her dependent role as a daughter to marry or, more especially, until after becoming a mother and having someone dependent upon her. Other incidents which forced responsibilities upon these women appear to create much tension and to cause regression to oral satisfaction. Although the responsibilities carried by a number of subjects appear from their accounts to be greater than usual, those subjects complaining most about their burdens had the lighter tasks. A third of these in whom this situation was studied regarded themselves as inadequate or overburdened.

Resentment toward husband, children, or other important persons was frequent. The fact that these women had not permitted themselves the expression of this hostility suggests a need of the patient to retain all sources of approbation and an excessive fear of incurring any disapproval. Recently Bychowski[19] indicated that compulsive eating, a cannibalistic introjective mechanism, may vent this aggressivity. Consumption of food is an aggressive masculine act, symbolic of earliest gratification by the mother, and places the subject in competition with the rest of the family for such solace. The initial purpose of retaining approbation and avoiding disapproval is thus defeated; instead anxiety and guilt result. These may further produce depression. In this series depression was prominent in only six cases. In these it was not

constant but recurrent in varying degrees. This is usually rationalized as guilt over not having followed the doctor's orders, but can usually be traced more deeply.

In a very few cases women who considered themselves unlovable or who felt undesired gained a fact in reality upon which to base their reasoning by eating and becoming unattractively fat. Their expressed dislike of any sexual activity suggests that it seemed easier to reduce sexual temptations through obesity than by more adult methods. Bychowski[19] also observed that once obese women lose their excess fat, one beholds creatures who fit the measurements of undeveloped girls.

After removing from consideration those who fell into the previous categories a large number remained for whom eating served a large variety of purposes. These might be expressed in either a neurotic or a psychotic setting. In general, however, overeating was associated with passivity, dependence, intolerance of responsibility, and repressed aggression, all amounting to emotional immaturity.

Conclusions

A. Considering the anthropologic and psychiatric factors, we may postulate in obesity the presence of genes which (1) accelerate total body growth rate, (2) tend to stop both physical and emotional growth earlier than usual through effects on the adrenarche and menarche, and (3) sensitize the hypothalamic appetite mechanism. The presence of all three of these genes or groups of genes produces a *potentially* obese person. The occurrence of stressful situations may precipitate overeating which is usually accompanied by other neurotic or even psychotic solutions.

B. Frequent personality conflicts are with passivity, dependency, intolerance of responsibility, and inability to express aggression.

Case Summary

A 37-year-old white woman returned for treatment by psychotherapy as an out-patient at the Curtis Clinic, Philadelphia, for over two years. Initially she was too heavy for the medical scales, but she tipped the freight scales at 317 pounds. She complained of extreme nervousness, excitability, and of "nervous headaches with a sick stomach" when upset. She described herself as over-

meticulous, fussy, disdainful of anything dirty, almost obsessively clean during her menses, and very concerned about financial matters.

Six months after her birth in North Carolina, she was taken to her maternal grandparents. An aunt lived with the grandparents, worked, and ruled the household in a domineering moralistic manner. The patient was the oldest of three siblings, and, when the two younger ones were brought from an orphanage this aunt chose the patient as her favorite, creating dissension among the children. The patient's brother died when she was 10, leaving a sister four years younger. The patient was unable to remember her siblings at all as children. Food was a source of solace even when she was young, especially as the aunt praised fatness as "cute." By menarche at the age of 14, she weighed 219 pounds.

The aunt was always preaching some moral or protecting the patient by locking her inside their fenced yard. This and the aunt's constant presence drove both other girls and boyfriends away. The aunt would give her approval to the patient's actions, only if tasks were completed with the utmost scrupulousness. The patient considered her a paragon of virtue and obeyed her implicitly. More recently the patient discovered that this aunt had been doing just what she had been hypocritically preaching against to the patient. Despite intellectual recognition of this and resentment of the aunt's continued domineering ways, the patient, before therapy, was unable to accept the reality of having any hostility toward her but was continually disturbed in her relations with the aunt.

The patient saw little of her mother until she herself was 19, as the aunt disapproved of the mother's marriage and refused to allow her to visit her. Occasionally the mother would sneak in while the aunt was at work. The patient has never seen her father whom the family has always described to her as a black sheep. When the patient was 19, the mother reclaimed the children and went to Philadelphia where the patient obtained work. The mother and sister made occasional ineffectual efforts to obtain employment but usually ran up such heavy bills for unnecessary trivia that they could not pay the rent and would be evicted. The patient felt so insecure that she took an evening business course, and a nursing course, and also learned to operate many types of sewing machines so that come what may she would be prepared. Upon learning that her sister was pregnant, she expelled her from the household.

Shortly thereafter the patient fled the situation by way of marriage. Although she gained much-desired financial security, her husband openly philandered. During a period of indecision, she put on a great deal of weight. However, after separating and finding work with a couple who took a sincere interest in her, she lost weight. "I lost 60 to 70 pounds. I was content." When her husband was hospitalized as psychotic and then died of a brain tumor, she felt very guilty and somewhat confused. In order to retain her home and to gain some advice, she married a friend of her husband's. Prior to therapy she was only aware of a vague admiration, not love, for this man, and even this was tempered by the fact that his seasonal work as a carpenter had not yielded the security she had sought. Likewise she resented his passive attitude. "I wish he would take some initiative, but he leaves everything up to me. I married for security but he leans on me."

This substitution of eating for security and affection was one of the first points utilized in therapy. She gradually came to see that she was making excessive, romantically idealistic, demands upon her husband and others, while not encouraging them by making initial friendly overtures. She had been hurt before and did not wish even to take a chance on being hurt again. Gradually this attitude and the behavior associated with it changed until, for the first time, she cut a trip short because of a loving longing for her husband. Friends remarked on her change of attitude from, "People say I am always wrong; no one likes me," to, "Maybe they won't like me and may hurt me, but I'll give them a chance."

Only with much trepidation did she transgress her early teaching of keeping all feelings bottled up. Her recognition, even in graduated small doses, of her strong hatreds and resentments was very disturbing. The evening before, and morning of, her appointments she frequently developed nausea or headaches which were promptly interpreted and accepted as resistance phenomena. "Whenever I don't want to do anything I get sick at my stomach." Occasionally she would give in to them but usually came despite their occurrence to experience a subsidence once the session had begun. Gradually she was able to verbalize her negative feelings more readily in the sessions, and was able to discuss them with her aunt and husband so that improved relations with each of them resulted.

In 10 months she had made fair psychiatric progress but had only lost 11 pounds. At this point she was given amphetamine (S K. F-42) before meals, as it was imperative for her to lose weight before undergoing an operation. She immediately complained of nausea and vomiting, dizziness, a sensation of being in a trance, retardation of movements, and a feeling that her voice belonged to someone else. The drug was continued. After about two months she spontaneously stated that the symptoms had been a resistance against losing weight. "Every time I've heard I've lost weight, I've fought against it. I'm afraid to lose it. I want to lose weight but, when I'm conscious of losing, I get sick at my stomach and all upset. Maybe people would be sorry for me if I'm fat. No, people leave me out of things because I am fat." (She gains sympathy and reduces interpersonal contacts, v. s.) Following this she had no more such symptoms and, during the ensuing year, reduced her weight to 250 pounds.

Unfortunately it was necessary for the therapist (R. S.) to leave the clinic area and for the patient to continue with another. She became irritable, fatigued, slept up to 11 hours a day, had headaches, and gained eight pounds in three weeks. She recognized a great resistance against coming for therapy, verbalized feelings of rejection by her former therapist and of uncertainty about her new therapist. "I don't know you. I'm always afraid of expressing myself for fear of being hurt." About this same time she obtained a daytime job, as her husband was again out of work, and she discontinued therapy.

Psychological tests indicated an IQ of 126 on the Bellevue-Wechsler Scale. The Rorschach and Szondi tests showed great constriction through the extreme anxiety of repressing her instinctual drives. There appeared to be a basic need for emotional dependance. However, in her intimate relations, she appeared cold and cautious until strongly stimulated when she lost emotional control in immature impulsivity. In her less intimate relations, she appeared to adapt better, but only through compulsive repressive means among which eating was prominent. By allaying anxiety in that way she could be relatively indifferent in her object relations, making few demands upon them.

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SIMULATION OF PSYCHOSIS

*A Report of Three Cases**

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While on the psychiatric service of an army general hospital in the Far East, the authors of this paper recently observed three cases of attempted malingering which they believed to be of especial interest for several reasons. In the first place, all three patients attempted to malinger a psychosis, which in the writers' experience had been a rare occurrence among the large number of psychiatric patients observed at this hospital. Second, they each had basic personality disorders of which the malingering was only one aspect; and there was no common denominator in the basic personality defects which one could readily correlate with the ma lingering. Third, in all three cases historical and clinical suspicions of malingering were confirmed by significant findings on psychologic test results. And finally, very little work has been published on the subject of malingering, particularly malingering of a psychosis.

Malingering is defined by the army as "The intentional, calculated attempt to produce or simulate illness or injury for the purpose of evading duty or responsibility."[1] This was used as one criterion for establishing the diagnosis of malingering in the cases here presented. An additional criterion adopted by the authors was absence of true psychosis. All three cases fulfilled the first criterion of a conscious and premeditated attempt to evade duty by feigning an illness. Two of the three also fulfilled the second requirement of having no mental illness. They were, therefore, recommended for appropriate administrative disposition. The third patient, Case 1, as will be seen, was also suffering from a true and severe mental illness which required psychiatric treatment. The malingering in his case was regarded as merely a symptom of his illness and was of academic interest only. It had no bearing on the final disposition of the case.

Since at this army hospital (141st General Hospital), routine psychologic testing is not done on all psychiatric patients, tests are ordered by the psychiatrist only in cases of unusual interest or in

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those cases in which tests would prove helpful in diagnosis and treatment. In all of the cases presented here psychologic tests were ordered specifically because it was believed from the history and/or the clinical picture that there was a strong possibility of malingering. As all three of the patients were believed to be feigning psychosis, the psychologist was asked the following two questions: (1) Is there any evidence of distorted thinking that would indicate a psychosis? (2) Is there any evidence of a conscious attempt to malinger a mental illness?

The Case Material

Case 1

This 28-year-old, white air force staff sergeant with four years of air force service was transferred from a nearby air base dispensary with a diagnosis of "manic-depressive reaction." The patient had served in the air force for three years during World War II, and apparently had had a good military record, terminated by honorable discharge. He re-enlisted about one year prior to this hospital admission and had been stationed in Japan for two months. He worked as a clerk and discharged his duties efficiently. During the two weeks prior to admission, his commanding officer noticed that the patient was drinking more than usual and that his efficiency at work had decreased noticeably. On the day of admission he drove off in a jeep without authorization, and, when apprehended, behaved so oddly that he was taken to the dispensary. There he was observed to be hyperactive and confused, so that he was immediately transferred to the hospital for psychiatric observation.

History. The history, as obtained from the patient, was not very helpful because of his mental condition, and there was no available outside source of information. He did disclose, however, that he had done fairly well in school and had completed two years of college. During the five years between his two tours of military duty, he had lived in southern California and was employed as a draftsman in an aircraft factory. He was interested in the theater and occasionally acted in little theater groups. There was no history of any previous psychiatric disorder.

Mental Examination. The mental examination on admission revealed increased psychomotor activity and overproductive speech.

This speech was circumstantial, and at times irrelevant. It was marked by clang associations, perseveration and a concrete fascination with words. The patient was very manneristic, exhibiting frequent symbolic gestures, such as exaggerated saluting in the presence of an officer and complicated motions of the hands that elaborated on what he was saying. He said that he heard voices saying that he looked like a certain well-known Hollywood actor (there was a superficial resemblance). No paranoid delusions or ideas of reference were elicited. He was well oriented in all spheres.

The clinical picture appeared typical of a schizophrenic reaction, and this was the initial diagnosis. Subsequent information obtained from the patient's commanding officer, however, revealed that the patient had recently inherited a fairly large sum of money —about $2,500. He then remarked to several of his friends that he would get home "any way I can." When he was questioned concerning this information, he at first denied it and then became very evasive. His mental status became less dramatic, but mannerisms and inability to form normal, abstract, intellectual concepts continued. Psychologic tests confirmed the clinical impression that this was a case of a schizophrenic attempting to malinger a psychosis. This impression was based upon the early overdramatic qualities, the history furnished by the patient's commanding officer, and the patient's evasiveness and change in mental status when confronted with that history.

A poignant development in this case was the gradual realization by the patient that the medical officers knew of his deception and that they, nevertheless, considered him mentally ill. He declared that he had been "playing a dual role" and that now "the play has become a sort of tragic comedy." It was difficult to determine how much was conscious acting on the part of the patient. It was believed, however, that the prognosis was grave, and that he could not be rehabilitated for military duty. He was, therefore, evacuated to the Zone of the Interior for further treatment and final disposition.

Psychologic Evaluation. On all tests there was evidence of marked qualitative variations, deviant verbalizations, queer content, and bizarre percepts. This patient gave a schizophrenic record on the Rorschach, the Wechsler-Bellevue Intelligence Scale and the Thematic Apperception Test. Despite the pathology clearly implied, the Rorschach was less dramatically deviant than the TAT

and the Wechsler. The patient's approach was orderly, his form level was good, and his content generally acceptable. It is true that when he did give deviant responses on this record, they were of a very serious nature such as contamination, M minus, and over-symbolization. It was on the TAT and Wechsler, however, that he became dramatically bizarre, grossly illogical, markedly disjointed and acted more like a popular conception of the psychotic. As with his clinical symptoms, so were his responses on these two tests, overdramatic. It is believed that the Rorschach (which offered him no frame of reference) elicited a truer picture, while the TAT and Wechsler represented an attempt by the patient to give the impression of a more serious illness.

Diagnosis. Schizophrenic reaction, type unclassified, chronic, severe, manifested by mannerisms, concrete thinking, and episodes of manic behavior.

Case 2

This 18-year-old, white, single private first class, with one year of army service, was transferred to the 141st General Hospital from an evacuation hospital in Korea with a diagnosis of "psychotic reaction, n. e. c." He had been in combat in Korea as an infantryman for about five months when he was evacuated because he appeared confused and disturbed. He repeated over and over again that he had accidently shot and killed his buddy three months prior to admission. He said that since that time he had become more and more depressed and could no longer continue in combat. It was reported by his unit commander that he had been an ineffective soldier and would not fire his rifle at the enemy. Notes accompanying him from the evacuation hospital described him as agitated, confused and at times disoriented.

History. The patient said that his parents had been divorced 13 years ago and that he and his older sister lived with his mother. He said that his mother was both physically and mentally ill, but he could give no further details about her condition. He had quit school in the tenth grade at the age of 16 to go to work to help support his mother. His work record was relatively poor until he enlisted in the army a year later. According to the history from the patient, his previous army record had been good.

Mental Examination. The mental examination revealed a rather agitated young man who was very dramatic both in telling his his-

tory and in his actions. He had a slight tremor and shook his head to and fro constantly, stating that this eased his severe, throbbing headache. He appeared superficially to be confused, but was well oriented in all spheres, and his answers to questions were relevant. There were no apparent delusions or hallucinations. He kept repeating over and over, "I won't go back to kill anybody. . . . I'm going to Hell. . . . They are all going to Hell. . . . They are killing people." Frequently, during the interview, he would appear distracted and stare off into space.

The initial clinical impression was that this was not a psychotic reaction, but merely the manifestations of a hysterical character. It was then observed that the man's behavior on the ward varied considerably when he noticed the presence of the ward doctor, from his behavior when he thought he was not being observed. When he realized that he was under observation by the doctor, his behavior was as just described in the mental examination. Otherwise he appeared rather calm and showed no evidence of confusion, agitation or head-shaking. This aroused a suspicion of malingering, which was confirmed on psychologic testing. The patient was informed of the suspicions of the staff, and also of the fact that he was not considered to be mentally ill. He was returned to duty with a stern admonition that further similar behavior would result in disciplinary action. A recommendation was sent to his unit for administrative disposition if he continued to be an ineffective soldier.

Psychologic Evaluation. The patient's production on the Wechsler-Bellevue was markedly unlike that elicited on the Rorschach. On the Wechsler-Bellevue, his answers were recklessly wild. Example: "London is in France," "The capital of Italy is Prague." His judgment was impaired. Example: If he found a stamped, sealed and addressed envelope, he would "find the owner." His performance IQ (70) was much higher than the verbal IQ (55). On the Rorschach, a different pattern emerged. Evasion was expressed by increased initial and average reaction times, minimal responses (12), rejection (1), asking the examiner to tell him what people are supposed to see in "these things anyway." Percepts had good form but were of the variety classified as "cheap." There were many easy D and P responses. No wholes were of a truly integrative variety. The dramatic failure on the WB, the extreme change of pace on the Rorschach, the evasiveness and even "cagi-

ness" of the patient in dealing with unstructured stimuli, all suggested that this patient achieved a full scale IQ of 57 by deliberately trying to depress his score on the WB where he knew what constituted an incorrect answer. On the Rorschach, where he had no frame of reference he resorted to evasion and blocking.

Diagnosis. Emotional instability reaction, chronic, severe, manifested by low tolerance to stress, episodes of disturbed behavior and possible desire to evade duty.

Postscript. After leaving the hospital, this patient continued to make concerted efforts to evade duty. He sought aid from at least two chaplains and from the Inspector General's Office. He even managed, a few days after leaving the hospital, to get admitted to another medical installation because of the behavior described in the foregoing. However, he was immediately transferred to the same hospital and quickly returned to duty for the second time.

Case 3

This 22-year-old, single, Negro private first class, with three and one-half years of army service, was referred to the neuropsychiatric clinic for psychiatric evaluation. He was awaiting court-martial for a 10-week period of absence without leave, and there was some question as to his present mental status and his mental status at the time of the offense. He had gone AWOL seven months before this examination, and, after being apprehended 10 weeks later, was confined to the stockade. While in confinement he made two suicidal gestures, one by hanging himself and the other by jumping from a wall. He was admitted to a station hospital for psychiatric observation and subsequently transferred to the neuropsychiatric service of the 141st General Hospital. The medical officer who observed him at that time noted that the patient refused to talk when first admitted, and later complained of vague feelings of strangeness and of seeing "visions" of strange people. He claimed complete amnesia for the period of absence without leave and confinement in the stockade. The diagnosis at that time was schizophrenic reaction, catatonic type, and evacuation to the Zone of the Interior for further treatment was recommended. However, because of his prisoner status, he was transferred to another hospital in the Far East for disposition.

Soon after arriving at the other hospital, he managed to escape, and was AWOL for about five weeks. He was apprehended by military police and suffered a minor injury to his foot while attempting to break arrest. When returned to the general hospital from which he had escaped, he again refused to talk for the first few days of hospitalization. There was evidence that he had been drinking heavily during the five previous weeks. He was discharged to full duty three weeks later, with a diagnosis of "alcoholism" and a certificate recommending administrative disposition. While in the hospital, he had exhibited no evidence of abnormal behavior or psychotic thinking. During the subsequent month, until he was referred to the clinic for examination, he carried on his duties in a normal manner.

History. The patient had had two courts-martial in the past—a summary court-martial two years previously for one month of absence without leave, giving a false official statement, and using an altered and forged certificate; and a summary court-martial one year previously for wrongful appropriation of a government vehicle. He was in combat in Korea for four months and was evacuated because of "nervousness." He was hospitalized for 20 days and then assigned to duty in Japan. Prior to the absence without leave for which he was to be court-martialed, he had twice before walked off his job and claimed amnesia for these episodes. His general attitude was recorded as one of belligerence and un-cooperativeness. The patient stated that his father died shortly after his birth, and that he had quit school in the tenth grade to help support his mother. He said that he had been a professional boxer prior to entering the army. There were many points in the history given by the patient which were at variance with the facts officially recorded.

Mental Examination. The mental examination revealed a rather stolid individual with no apparent anxiety or depression. He claimed complete amnesia for certain periods, as described in the foregoing history. He also stated that he still had vague feelings of strangeness and occasionally heard voices calling his name. However, he appeared clinically to be in good contact with reality, and it was suspected that he might be attempting to malinger a mental illness. Psychologic tests were administered and confirmed the clinical impression of an anti-social personality feigning a severe mental illness. He was returned to his unit with a

recommendation for administrative disposition after whatever disciplinary action was considered indicated.

Psychologic Evaluation. The test battery results were characterized by striking qualitative differences on the individual tests. While he achieved a full scale IQ of a mental defective on the Wechsler-Bellevue (IQ 57), the estimated Rorschach IQ was well within the normal range. Reaction time in each test differed considerably, Rorschach percepts coming forth with apparently greater reluctance and hesitation than those on the Wechsler. In responding to the Rorschach, the patient continually appealed to the examiner for a hint as to what was expected of him. Although formal qualities were deviant and defective on the intelligence test, they were quite acceptable on the Rorschach. Percepts were clearly seen and well integrated. Content was not spectacular. Determinants were not remarkable.

His pattern on the Wechsler was consistent. He would answer the first few questions satisfactorily and then begin to give defective responses. Consequently, there was practically no scatter among the subtests. When pressed on a particular item, he would eventually give an acceptable answer, thus indicating that he was capable of doing so from the start. It was, therefore, felt that the patient had made a conscious attempt to depress his Wechsler score and to give distorted and atypical responses.

Diagnosis. Anti-social personality, chronic, severe, manifested by repeated absences without leave, poor social adjustment, two suicide gestures and an attempt to malinger a mental illness.

Discussion

These three cases illustrate pointedly the need to consider malingering in the light of the underlying personality pattern, and not as an isolated entity. No two of the foregoing cases were alike. The first patient was a true psychotic, who, incidentally, was malingering a psychosis. The second was an immature, emotionally unstable individual, who was "acting out" in a hysterical manner. The third was a coldly calculating anti-social personality, who would probably fall into Cleckley's[2] group of true psychopaths. In all three cases, however, the attempt to malinger was on a conscious level, and all three chose to malinger a psychosis.

There was a marked dissimilarity in the types of situation from which each malingerer was trying to escape. In the case of the air

force sergeant, it was a relatively mild stress of overseas duty in Japan. In the case of the infantry soldier, it was the very marked stress of combat. The third case, so often seen in civilian as well as military life, was an instance of a person attempting to escape from the consequences of criminal behavior by feigning illness.

One can only speculate as to why these particular individuals chose psychosis as the type of illness to malinger. In the case of the schizophrenic, it might be said that it would be only natural for a schizophrenic attempting to malinger a mental illness to choose schizophrenic symptomatology. Bowman,[3] in 1920, pointed out the relatively high incidence of psychotics malingering psychosis. This may represent a kind of schizophrenic withdrawal from reality.

With the presence in the same individual of both unconscious—or real—schizophrenic symptoms and conscious—or malingered—schizophrenic symptoms, it is interesting to speculate which of the two came first, which is cause and which is effect. It may be that a schizophrenic break had been impending in this case for a long time, and that the malingering episode represented a dropping of defenses against the psychosis. If this were so this dropping of defense could be on either a conscious or unconscious level, or on both. In any event, the writers believe that such a surrender would portend a very grave prognosis. Another possibility is that this patient's actions may have been a symbolic cry for help from a very sick patient.

Although it is usually difficult to make an absolute statement that a man is malingering, it would appear from the writers' experience that psychosis is an extremely difficult illness to malinger without arousing strong suspicion. In only one of the three cases described did the patient get by the initial interview without alerting the examiner to the possibility of malingering. This was the case of the man who actually was suffering from a schizophrenic reaction. Although it was noted when he was admitted that his symptoms were somewhat dramatic, even for a schizophrenic, there was no thought that he was malingering until this possibility was called to the writers' attention by subsequent history received from outside sources.

In each of the other cases, suspicions were aroused by several features of the clinical picture. The young infantryman appeared

to be excessively dramatic; and, although he had a superficial air of confusion, there was no real evidence of disorientation, defective thinking, delusions or hallucinations. The marked change in his behavior when he knew he was being observed was especially striking. The third man gave a history of vague feelings of strangeness and hallucinatory experiences, but showed none of the real emotional reaction that one would expect from a schizophrenic relating such a story. He also failed to show any loss of conceptual thinking although this was difficult to judge because of his evasiveness. His facile explaining away of his alleged criminal acts by claiming circumscribed periods of amnesia was also highly suspicious, as were the numerous points where his story varied from established facts.

In the psychological tests, suspicions were first aroused by inconsistencies between the individual tests within the battery. In general, these were expressed as dramatic and deviant performances on the TAT and Wechsler, while the Rorschach yielded evasive but less distorted records. In general, the Rorschach was viewed by the patients as threatening, and was met with reluctance and with appeals to the examiner for clues on how to respond. This was not the case in those tests where the patient had some idea of what a deviant answer would be. The Wechsler was usually characterized by grossly irrational responses which depressed the raw scores on all the subtests. Scatter analysis among the subtests revealed a caricature of what appeared to be the basic personality organization of each patient. Thus, the schizophrenic subject, the one with character disorder and the hysteric exaggerated in the direction of each of their respective disorders. The TAT in the case of the schizophrenic was similarly felt to be an exaggeration by the patient of bona fide symptomatology.

Conclusions

1. Malingering cannot be considered as a separate clinical entity, but only as one manifestation of an underlying personality disorder.

2. There is no specific personality disorder common to all cases of malingering.

3. The attempt to malinger a psychosis can be detected without undue difficulty if the examiner is alert to certain incongruities in the clinical picture.

4. Psychologic tests, when considered in the light of clinical findings, are very valuable adjuncts in establishing a diagnosis of malingering where there is simulation of a psychosis.

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SAMPLES AND CONTROLS IN PSYCHIATRIC RESEARCH

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Introduction

The establishment of the Rockland Research Facility late in 1952 provides a unique opportunity for investigation of deviant behavior. The staff was drawn together (from all parts of the world) by the shared conviction that a common conceptual framework must be evolved that is capable of including within itself all the sciences and disciplines concerned with the description and investigation of deviant behavior. Since most of the researchers were already trained in two or more fields, it was possible to begin working into this new area with unusual ease; the "sets" and prejudices of the single field specialist being at a minimum. The following paper is one of a series which critically reviews the methods, theories, and presuppositions of the social and biological sciences as they apply to our problem.

Critique

The purpose of scientific research in psychiatry, as in the physical sciences, is to control, predict and explain. One can begin with explanatory theory and seek for deduced empirical correlates or follow the reverse course of building a theory by induction to "fit the facts." In either case scientific procedure requires classification; the separation of the material being studied into identifiable classes. The attributes (properties) of such classes of individuals or objects provide one essential source of observational data. The other great source of "raw data" is the effect on such classes of identifiable procedures including "naturally occurring" environmental determinants as well as more specific experimental procedures. Ultimately, on the basis of results obtained by the application of these two basic techniques, the generalizations which constitute the "laws," mechanisms or principles of science are deduced and induced. Attributes of classes constitute such properties as the hardness of gold, the speed of light, the iodine uptake of schizophrenics, and the degree of anxiety in neurotics. Heat-

*Considerable clarification of many of the major points of this paper resulted from conferences with Dr. Donald L. Gerard. However, the author assumes full responsibility for the final formulation.

ing the gold, "bending" the light, giving thyroid-stimulating hormone and administering psychotherapy are all examples of procedures which may then be evaluated in respect to how they affect the gold, the light, the schizophrenics and the neurotics.

The apparent ease of such experimentation in the physical sciences is the result of standardization of techniques suitable for inorganic matter and may be highly deceptive if these same methods are applied directly to the biological sphere. This has been particularly true in investigations of deviant behavior, and one of the least recognized but most important sources of experimental error has been the selection of samples and controls with the uncritical assumption that the manner of selection used in the physical sciences is perfectly adequate for biological material.

There exist, however, important and crucial differences in the nature of psychiatric samples and controls which must be recognized and acted upon if results are to have validity or even reliability. In the physical sciences, one ingot of standard 24-karat gold, for example, is as good as another if conditions are identical; or one beam of white light under standard conditions can be expected to behave just as any other would. The assumption has been blithely made that one group of schizophrenics (or any other diagnostic group) is as adequate as another in determining attributes or the effects of procedures. Whether atoms of gold possess "individual differences" is, for most purposes, a purely academic point, since they are ordinarily dealt with in such large numbers that any individual peculiarities are cancelled out; and the conclusions, although perhaps statistical in their final analysis (as Reichenbach[1] maintains), are reliable and valid for all practical purposes. This permits dealing with the object matter of the physical sciences as a field of what Weaver[2] describes as "unorganized complexity."* The limits of populations to be investigated in psychiatry are determined not only by economic feasibility and available manpower, but by the very fact that certain classes of deviant behavior, even if taken in their entirety, would be infinitesimal compared to the number of atoms in a sample of gold. Consequently, one cannot take a sample consisting of 1,000 schizophrenics and assume the "individual differences" will cancel out so that the sample can be assumed to be equivalent to another sam-

*Where the "complex" of material is of such a nature or size that any organization into subclasses can be ignored, i. e., considered as "unorganized."

ple of 1,000 schizophrenics, or comparable to 1,000 manic-depressives or psychopaths. Without the consideration of other qualifications, there is no assurance that the attributes of this particular group or the effects of certain processes on the particular group would have reliability or validity for individual cases or even for other samples of the same size.

Physical nature is also considerably more kind in usually holding still while it gets investigated. Even when physical elements are changing, they generally do so in a regular or predictable manner (e. g., radium). Biological material, particularly psychiatric, squirms about and transfigures itself in an un-co-operative manner. Until the "laws" governing such behavior are much better known, we must use methods which take cognizance of this extreme motility. The striking reactivity of biological organisms to test situations and instruments multiplies Heisenberg's principle of indeterminancy to the nth degree. The application of a sphygnomanometer probably changes the blood pressure; questioning a patient about his hallucinations undoubtedly effects the nature of the voices or visions. Some excellent methods have been devised for dealing with this problem; but in many fields of psychiatric investigation there still exists considerable naïveté in assuming that the effect of the test situation itself can be neglected.

In the physical sciences, it is also generally possible to isolate "pure" samples of whatever it is one wishes to study. In the field of psychiatry one cannot obtain an uncontaminated sample of the id, of schizophrenia, or, for that matter, of adrenal 17-ketosteroids. Occasionally, this obtaining of a "pure sample" is relatively possible, as in a recent study where 2,970 subjects were rejected on the basis of as few as 12 "complicating" factors to obtain 30 "pure" cases. But general conclusions drawn as to the child-rearing tactics and attitudes of the parents of schizophrenic patients on the basis of this study are highly questionable since they were not studied in the context in which they are usually found.

The interrelatedness and lack of functional independence in the biological sciences exceeds anything in the physical sciences. Pressure, temperature and the few other physical "invariable variables" can be either controlled or measured. The biological organism at the human level has interdependent respiratory, circulatory, urogenital, gastro-intestinal, and nervous systems, none of which can be held absolutely constant or tested separately. Thus, not

only is it impossible to obtain pure samples but it is also difficult to control or measure the factors influencing the "in context" sample.

Another contrast between the physical and biological sciences is the interesting fact that organisms probably behave as something other than the sum of their individual parts, even if these could be completely investigated. The uniqueness of an individual is something over and above the sum of its parts. It is impossible to subdivide samples of a particular individual—as can be done with inanimate objects—and assume that each part is representative of the whole.

The final and most essential difference that bedevils the investigator, at the level of research, is the validity and reliability of taxonomy. The classes, types and groupings of individuals having mental disease possess little of the concreteness and testability of classifications in the physical sciences. Class criteria have not been firmly established, and failure to find them probably indicates the inadequacy and inaccuracy of present diagnostic categories. The writer's personal feeling is that this has resulted from a failure to approach this problem experimentally.[3] Regardless of the reasons or the solution, we are all well aware that a group of "schizophrenics" does not possess the operational definability or the theoretical integrity of the gold ingot.

Most of the biological sciences, and psychiatry which is our particular concern, have certainly not advanced to the stage where the methods of sample selection and control analysis can be adopted *in toto* from the physical sciences. Even more fundamentally, it is probable that an adequate description of the material with which we work will never be obtained with a model constructed to deal with inanimate nature. It is necessary to use methods of sample and control selection more compatible with our present stage of development and with the nature of the material with which we are dealing.

Representativeness

In the search to provide valid generalizations about attributes or procedures, it is impossible to study the total population. The obvious requirement is that the sample selected should be *representative* of the larger aggregate from which it is drawn. When groups are contrasted to determine attributes or divided to test

the effect of processes, the groups contrasted should be truly *comparable*. The following pages deal with these problems of representativeness and comparability as they apply to the area of deviant behavior.

The most common error made in the choice of samples for psychiatric research is to select samples solely on the basis of the currently accepted diagnostic category. Psychiatric subjects should be described and/or selected, not in terms of a single (questionable) criterion, but in terms of all the pertinent physical and psychosocial variables. The total population must be described along all main ordinates before it can be determined whether a sample is truly representative.

The age and sex of the patient are examples of attributes which are not directly a part of the pathological picture. Because of the obvious pertinence of these two physical factors they are almost invariably included in describing psychiatric subjects. Other physical factors, equally pertinent, are usually neglected. In a recent article,[4] the writer and co-workers reported failure to confirm the findings of testicular defects in schizophrenics as reported by Hemphill, Riese and Taylor. It is known that nutritional status is related to testicular structure and function. Thus, in current studies comparing schizophrenics to "normals," one must have adequate description along this segment of the physical parameter. If the hospital diet had led to nutritional deficiencies which affected the testicles, one would have to know this in order to determine whether any differences found between the two groups were attributes of schizophrenic vs. "normal" groups or nutritionally-deficient vs. nutritionally-adequate groups. With the related physical factors adequately described and controlled, the conclusions are much more likely to be both reliable and valid.

A real problem exists as to what should be included in an adequate physical description. Certainly all such physical factors as have been definitely shown to bear some relationship to the condition being studied must be included. As many as possible of other physical factors which are suspected of such a relationship should also be described. Needless to say, such description should be as uniform and complete as possible.

This same procedure should be followed with respect to psychosocial factors. Uncertainty as to which elements of the psychosocial parameter to include, or how to describe them, has led to

many debatable and contradictory findings. For example, differences in discharge rates between state hospitals and certain private sanatoria may be due not only (if at all) to therapeutic orientation, but to the ability and interest of the patients' families in maintaining the patients at home. Unless this situation is described, the question remains unanswered. Such examples could be endlessly multiplied. Even within a single culture the mores of various groups differ so widely that if all, or a majority of, the subjects are drawn from one such group it is difficult to avoid attributing universality to "pathological manifestations" which are really only attributes of a particular type of family or societal structure.

It is not essential that the sample represent these physical or psychosocial factors proportionately as they exist in the total population, but there must be sufficient representation so that analysis of variants can determine what is and what is not a related attribute of the group being studied. It may well be argued that a method of sample selection which requires the description of even one total hospital population in respect to all probably pertinent variables is impractical because of limitations of time and personnel. Certainly it is not a task to be undertaken lightly; but in view of the effort currently devoted to psychiatric research it is by no means prohibitive, and the "total" population need not be studied at one time. Any institution which intends to carry out intensive or extensive research on a particular group of patients must select the sample to be studied by such a procedure if results are to have applicability to the nonsample part of the population. Results cannot be validated or reliability tested by other investigators unless this is done. Nor, more importantly, can samples of related but different populations be compared to demonstrate the "universality" of the conclusions or findings. The application of this method to the selection of a sample of chronic schizophrenics has been made at the Rockland State Hospital Research Facility.[6]

It is perhaps well to pause at this point and dispel the myth of randomization. The view is still prevalent in some quarters that if you "grab without looking," your sample—by some statistical magic—will be representative. It should be clearly understood that random selection is most effective after accounting for all the *known* and suspected variables. Random selection is then of use in helping to eliminate any systematic bias in the *unknown* variables. Public opinion polls, for example, first stratify the pop-

ulation according to factors which are known to be related to particular attitudes being studied. Only within such stratified layers where known variables are already accounted for, is there possible the best application of the techniques of random selection.

The possibility of doing research in a less elaborate setting is not precluded if all these conditions cannot be met, but it does place very definite obligations on researchers who are working on samples of patients not selected in this manner. The pertinent varibles must still be systematically described so that such data may be evaluated in respect to variables which could not be controlled or analyzed. Further, the researcher should be most diffident about claiming universality for his conclusions, since he has no way of evaluating how representative of the total population his particular sample is.

The closer the description of such a group of patients is to an unqualified "these 26 schizophrenics," the more useless it is to other investigators now or in the future. The principle of including an anamnesis of each case used in the study is highly laudable. If it could be done in a complete and systematic manner, important and extensive studies would not be nullified or questioned by the finding or conjecture of new related variables which the original researcher described but could not evaluate. The problem remains to find the best method of selecting a sample of patients by the researcher who does not have available the facilities for selecting a sample fully representative of some larger aggregate and who is aware that he must describe those subjects that he uses along the important parameters.

Since the relatively small number of cases likely to be at his disposal are prohibitive of co-variant analysis of all factors involved, it is strongly recommended that such researches be done on as homogeneous a group as possible. The investigator in any case will not be able to claim representativeness for his sample. He actually has more chance of unearthing reliable and valid findings and making important generalizations if he keeps the number of variables as limited as possible. Practical considerations will, in any case, limit the number and variety of patients amenable to testing. In addition, the nature of the attribute or the procedure being investigated will enter as a determinant of which patients are to be studied. A fuller illustration of this technique is given elsewhere.[6]

The nature and purpose of the investigation determine the criteria. To illustrate this, if the research were concerned with certain biochemical measures in psychotic, as contrasted with non-psychotic, pregnant women, the criteria for admission to the test population might be:

1. Age. Only females between the ages of 25 and 35 would be studied—in order to eliminate the possibility of late menarchus or early menopause.

2. Health. The subjects should have no disease or anomalies of metabolism which are related to the biochemical function in question other than the pregnancy.

3. Primiparity. Since the effect of previous gravidity is unknown, only subjects pregnant for the first time would be included.

4. Nutritional status. Since the biochemical function might be dependent on nutrition, all subjects should be adequately nourished.

5. Attitude toward pregnancy. Since emotional factors may influence the biochemical levels in question, subjects should be drawn from social groups and families having the same attitude and education in respect to pregnancy.

By limiting the number of variables it becomes much more probable that other investigators could repeat the experiment with similar results. Further, other investigators could extend the universality of the results by changing one of the population criteria. The experiment might be repeated on multiparous instead of primiparous subjects.

The entire population of such patients available should be surveyed and described before a sample is selected. Remaining variables which are felt to be related should be included in a manner that will permit their statistical evaluation. If there are insufficient numbers, either the group should be further restricted to make the population more homogeneous, or if this would limit the total population too much, note should be made of these factors for each subject and data presented in such manner that the distribution can be determined. If it is felt that all related variables have been either accounted for or are contained in the criteria for population membership, random selection of the sample is then in order.

Once the selection of the sample has been completed, there may be other practical considerations. If the granting of permits by

the family is required; if a certain degree of docility of the patients is essential because the tests require co-operation; or if other such limiting factors exist, a new problem arises. The exigency can be avoided, of course, if these requirements are included as criteria for population membership. At times it is necessary to eliminate subjects after the sample has been selected. The characteristics of these subjects and the reason for their elimination as samples should always be noted and included in the final presentation in order to provide the data with maximum usefulness for other investigators.

Comparability

Once a test sample has been demonstrated to be representative, the next step is to compare it with other samples from the same or different populations. There exist three major methods of comparing: the intra-individual, the intragroup, and the intergroup methods. Each of these serves a different purpose and considerable difficulty can arise if a method of comparison is used which is unsuitable. The intra-individual method is suitable only for testing reversible procedures; the intragroup method is suitable for testing either reversible or irreversible procedures, and the intergroup method is suitable only for describing properties, characteristics, or attributes of one group in contrast to those of another group.

Intra-individual Comparisons. When the number of subjects to be tested is small and the number of variables is either unknown or numerous, the intra-individual comparison is the method of choice for evaluating a reversible procedure. Since the subject acts as his own control, the unknown variables, although they still remain unknown, can be regarded as relatively constant. If the experimental design is adequate, the effect of a particular process or procedure on a particular group can be measured.

An example of this is an actual experiment in which the question asked was whether and to what degree dibenamine influences catalepsy in catatonic patients.[7] Only nine such patients could be found in the 2,500-bed Veterans Administration Hospital, Lyons, N. J., in whom the degree of catalepsy satisfied the criteria and the variables relating to the occurrence of catalepsy were unknown. It is obvious that dividing the patients into three "simultaneous" groups to compare the effects of dibenamine, sodium amytal and

sterile saline would be most inconclusive because of the small number of patients in each group. If all nine patients were simultaneously tested on saline, subsequently on sodium amytal and still later on dibenamine, there would exist the possibility that any changes which were noted might be related to such factors as increased contact and stimulation not deriving directly from the drugs themselves, but to other factors which were present on one day of testing and not on another. The nine patients were, therefore, divided into three groups of three subjects.

In the first period of testing (which extended over several days) three of the patients were given saline, three amytal and three dibenamine. At the second time of testing, after a lapse of two weeks, the group which had received the saline now received amytal; the group which had received amytal now received dibenamine, and the group which had received dibenamine now received saline. Again, after a lapse of two weeks, the third test period was instituted. Those patients who had received saline and amytal now received dibenamine; those who had received amytal and dibenamine now received saline, and those who had received dibenamine and saline now received amytal.

Had all the nine patients on any test period shown similar changes one would have had to discount the effect of the particular procedure. Or had all the patients shown progressive changes regardless of the order of the tests from the first to the third test period, it would have been obvious that factors other than the injections were operative. Further, had any one of the injections brought about major irreversible changes this too would have been revealed. Had this last possibility been realized, i. e., if an irreversible change had been effected, the results, although stimulating, would have been inconclusive since the method of comparison would have been inadequate to determine whether or not this irreversible change was really due to the injection.

Unfortunately the intra-individual method is too frequently used in evaluating irreversible procedures such as prefrontal lobotomies or psychotherapy. A particular patient, subsequently lobotomized, who did not previously respond to "total push therapy" or to the more frequent "custodial-care therapy" in use at many hospitals, may achieve a recovery following lobotomy. This does not demonstrate that the operation was the necessary cause of the improvement. Similarly, the fact that a formerly impotent patient

achieves potency after four years of psychotherapy does not of itself demonstrate the efficacy of psychotherapy in effecting potency. In the case of lobotomy, any number of unknown variables may have been at work which were not directly related to the operative procedure. Shifting the patient from a back ward to a pre-lobotomy set-up with increased attention and an air of expectant optimism, or the subsequent post-lobotomy "re-education" process are uncontrolled variables in the case of intra-individual comparisons. The implicit comparison of these patients with others not so treated assumes either intra- or inter-group comparison. Because it is not done systematically or with awareness, it is the poorest type of control. Further, this is no longer an intra-individual control.

Similarly, the fact that a person is concerned enough about his neurotic condition to seek and continue to pay for psychotherapy over a period of years may introduce a selective factor. The willingness to undergo such treatment may augur a high capacity for self-recovery, and the relief from the neurotic symptoms might well have occurred with or without treatment. The fact that the subject may have possessed the neurotic trait for years previous to treatment is not conclusive, since the fact that he finally went for therapy may indicate that a new factor had entered. Oddly enough, the only convincing demonstrations, with intra-individual control design, of the effects of therapy are when the patients relapse into their original illnesses after therapy is discontinued. Comparisons of patients undergoing treatment, with those not receiving treatment, immediately shifts one to discussions of intra-group or intergroup comparisons.

In view of practical considerations, compromises with adequate research design are sometimes necessary. The practice of utilizing intra-individual control technique with a so-called "dry run" has had a recent vogue. Prior to carrying out an irreversible procedure, the conditions of the experiment are simulated except for the crucial procedure itself (e. g., lobotomy) and response to this "dry run" is accepted as an adequate control. It can only be re-emphasized that intra-individual controls are never completely satisfactory for irreversible procedures. Although this technique is a refinement which does possess merit, its use should be restricted to cases where more suitable control design is not possible, and

conclusions from this method can be accepted only tentatively until data provided by more suitable controls are obtainable.

Intragroup Comparison. This is the method par excellence for evaluating processes and procedures. Full realization of the extent to which intragroup comparisons can be made and their vigorous application would clarify many disputed areas in psychiatry.

Before discussing *intra*group controls it is well to point out that *inter*group comparisons are never suitable for the evaluation of procedures, although, knowingly or unknowingly, they are often used for this purpose. The first and by long odds the most common mistake is to assume that individuals belong to the same group (i. e., are intragroup members) when they have only a portion of related attributes in common. Frequently a group, equated as to pathological symptoms, is then divided for the purpose of intragroup comparison in such a way that physical or biosocial aspects are entirely unequal. If determining variables exist in either of these latter two parameters, unwarranted effects are attributed to the procedure being evaluated.

Examples are manifold. Interest of the family in a patient, for instance, not only has bearing on the patient's own emotional response but may determine whether placement outside the hospital is possible when a certain degree of social recovery has been achieved. If the procedure being tested is prefrontal lobotomy, a selection of patients is ordinarily obtained in whom pathological symptoms are roughly equivalent. In testing therapeutic effectiveness, these patients *cannot* then be divided so that those for whom permits for operation are not obtainable are used as controls for those for whom the necessary operative permits are obtained. It would be highly probable that those families who granted operative permits had considerably more interest in their patients than those who either failed to respond or refused permits. Discharge from the hospital might then be dependent on factors unrelated to the operative procedure and thus produce a false impression of the effects of operation. In actuality, this procedure is then no longer an intra- but an inter-group comparison between one class of patients in whom operative permits are obtainable and another class where they are not. The attribute of "being discharged from the hospital" is contrasted in the two groups, and no final data about the therapeutic effect of lobotomy are being provided, although the first group receives the operation and the second does not.

Unless all the facets of description are considered, errors will continue to abound. What was intended as an intragroup control design, adequate to evaluate a procedure, may otherwise, without the experimenter's awareness, become an intergroup comparison. The establishment of attributes may be mistaken for demonstration of the effectiveness of a procedure.

It is extremely unlikely that a population of individuals can be divided into two, three, or more groups with exactly equivalent distribution of known or possible related variables in all the areas of description for each subject. In other words, matched controls are rarely available, and, for that matter, are an unnecessary refinement. The sole requisite is that an adequate representation of each of the variables be present in each of the subgroups so that analysis of the influence of a particular variable is possible.

When a matter such as oral dependency, Oedipal fixation, slum environment or similar process is the subject of investigation, the intragroup may include not only all types of mental disease but a large population of "normals." As long as description is adequate in all known respects, and as long as test and control groups contain sufficient numbers of subjects for statistical evaluation of the variables, no limit exists to the number or kinds of members of the "intragroup."

As with procedures of shorter duration, the *inter*group comparison is unsuitable for evaluating these long-duration irreversible processes, since the sole function of intergroup comparisons is to characterize or describe the properties or attributes of the groups themselves. To demonstrate that schizophrenics are fixated at the narcissistic level or that they come from families with a particular social organization, carries entirely different implications than saying that a narcissistic fixation or a particular familial organization has some causal or influencing effect on schizophrenia. Narcissistic fixation, familial organization, or what you will, may be ineffectual and nonoperative as a procedure or process and yet be perfectly valid as a characteristic, property, or attribute.

Failure to recognize this distinction, in respect to these more extended attributes or processes, has again resulted in attributing functional effectiveness to factors or events which possess validity only as attributes. Narcissistic fixation or familial organization may be investigated either as an attribute or as an effective pro-

cess. Intergroup controls are necessary in the former case and intragroup controls in the latter case.

Whiteness and a certain degree of coldness can both be shown to be attributes of snow. By intergroup comparison it can be demonstrated that these attributes of (the class) snow do not occur in (the class) rain. Cold as a procedure (i. e., making the rain colder) is one of the effective and essential procedures or processes in the creation of snow. White, on the other hand, as a procedure (i. e., making rain white, perhaps by adding some chemical) is meaningless and non-essential in the creation of snow. Thus, although both whiteness and coldness are real properties of snow, only the cold is an effective agent in the process of converting water into snow.

Only intragroup comparison enables one to evaluate the effectiveness of such a procedure, in which case two samples are drawn from a "population" of water. Snow formation is induced or aided in the sample made colder. "Whitening" a sample has no effect on snow formation.

When the experiment is designed to evaluate a process or procedure that has occurred in the past, a real problem exists. For instance, the role of parental rejection as an *effective* factor in the etiology of schizophrenia may be the subject of investigation. How to determine the degree to which an attribute is possessed by groups of schizophrenics in contrast to other groups, will be discussed shortly under "intergroup comparison." How to determine whether a factor has been effective is not always possible. Ideally, one should take an adequate population in which all other factors known or suspected of causing schizophrenia are equated sufficiently for statistical analysis and, then, by random selection, have half of the parents "reject" their children. In addition to the need for then following the samples throughout their entire lives—and even providing there existed good operational definitions of "reject" and assuming that all the parents so selected would comply by "rejecting" at request—one could then conclude only that parental rejection was involved in the causal or effective chain, but was not necessarily the sole or direct "cause." To circumvent these almost impossible conditions, it is common practice to attempt evaluation of the extent to which a process is an effective cause in a *post hoc* manner.

To determine whether schizophrenics have a higher rate of parental rejection than non-schizophrenics neither proves nor disproves the role of a parental rejection as an effective agent. It may, for instance, be that schizophrenic children are recognized (albeit unconsciously) as being unhealthy, unlovable, difficult, odd, etc., and this results in the normal, healthy parent "rejecting" them. In this case the procedure of rejection would be resultant rather than effective.

Is there then any way in which an effective (causal) role can be demonstrated in this case? The answer to this is a matter of how the question is asked. If even one case of schizophrenia can be found in which the parents were nonrejecting, we can conclude that the process is not either the sole or a necessary factor in the etiology of schizophrenia. If no case of parental rejection is found among the schizophrenics we cannot conclude that it is not a "cause" but only that it is not an effective process in the sample and population studied. If, as is more likely to be the case, the schizophrenic group may possess an attribute in a significantly higher degree than the control sample, we could not determine its etiological effectiveness without other knowledge.

The "joker" in the pack is that there is no way, in this illustration, of controlling or recognizing the factors which may bring about a selective bias in those cases where the parents do reject the children. It may be, as mentioned, that the schizophrenia in the children brings about rejection. It may be that rejecting parents have a low capacity for emotional response and that it is this, or some other "correlated" but dynamically different factor rather than "rejection," which is effective. Unless selective bias can be controlled or known, we can determine only attributes and cannot evaluate effectiveness of procedures or processes.

In other cases, such studies are possible. Bender, Goldfarb and others have suggested that institutional upbringing is a factor in the "creation" of psychopaths. An adequate intragroup population can be reconstructed. Let us, for instance, set criteria for population membership as follows:

1. Only children, from white, native born, Protestant, middle income families with no close relatives other than parents.
2. All children born of mothers free of serious illness or nutritional deficiencies during pregnancy and with uncomplicated labor.
3. All members of population born within a six-month period.

4. Either to be controlled by criteria of admission to the population or by adequate sample for statistical analysis are the following: (a) sex, (b) medical illness, (c) reason for institutionalization. It may be expedient to use as population criteria only those children whose placement is necessary because of the accidental deaths of both parents.

The test group might consist of children raised in a representative sample of institutions and, as comparable control groups, children raised in foster-homes and children raised in their own homes (where both parents are alive). Care would have to be exercised, so that a selective factor was not involved in the choice of children for foster-homes both because the foster-home-placed group might possess some essential attribute (other than the foster-home placement) and also because if this were the case, the institutional population would then be depleted of this factor and a selective bias introduced in comparison with the other control group.

If the experimental design were adequate, a significant difference in the rates of such institutionalized children who became psychopaths would then lead one to believe that some factor was operative in the process of institutional upbringing that resulted in an increased incidence of psychopathic personality.

This type of conclusion leads to one final important point about the nature of processes or procedures: namely, determining the limits or borders of the process. It is extremely easy to slip into the error of attributing effectiveness to the most obvious feature of the process when this is not necessarily the case. What specific process in the larger over-all process was effective in producing psychopathy cannot be determined without a new investigation. To cite a previous example, it may not be the severing of the frontal lobes, but some other factor in the process of lobotomy that effects improvement. The degree to which the effective process should be isolated and identified depends entirely upon the purpose of the investigation.

For clinical therapeutic purposes, an "extended" process may be perfectly adequate. For other purposes, knowledge of the most minute limits of the procedure is required.

Intergroup Controls. These are correctly used only to identify the attributes or properties of a particular group. Further, they are the only legitimate means of identifying such properties or attributes. The permissible variations in the size and variety of the

group have sometimes beclouded the fact that this particular design must be so used. In addition, the necessary control group is frequently assumed instead of being made explicit.

Suppose that we wish to investigate whether a particular attribute exists in all hospitalized patients. The sample, as has previously been pointed out, must be representative of the group it is taken to represent, so that all types of hospitalized individuals would have to be included. If such an attribute were found, it might be desirable to know if this attribute were unique in these hospitalized subjects. It cannot be assumed that this is the case without actual investigation. The attribute must then be searched for in a control group of non-hospitalized individuals. The control group of non-hospitalized individuals may be a comparable sample of *all* non-hospitalized individuals, all non-hospitalized individuals in the same community, all non-hospitalized individuals who are also not clinic patients or in jail or in the county poorhouse. The criteria for membership in the control group should be just as explicitly determined and stated as for membership in the test group.

As another example, the determination that schizophrenics who are discharged from the hospital, in contrast to those not so discharged, are those who have a particular type of endocrine organization is a legitimate function of intergroup control design. Again it should be pointed out that this in no way evaluates the effect of the endocrine system on the course of schizophrenia. This same problem could also be expressed in terms of an intergroup comparison between schizophrenics with one type of endocrine organization and those not having that type of organization, with "eventually being discharged from the hospital" as the attribute. The same experiment, however, cannot be used, since adequate and representative samples might differ considerably in the two groups. Similarly, intragroup comparisons which test a procedure cannot be automatically assumed to produce adequate samples or data for attribute analysis. Entirely different sample selection criteria may be necessary to demonstrate attribute belongingness.

There exist various types of intergroup controls. Schizophrenics may be contrasted with other types of mentally ill patients (pathological-pathological); or one type of schizophrenic (hospitalized) may be contrasted with another type of schizophrenic (non-hospitalized). This is also another example of the pathological-patho-

logical control. Schizophrenics may be contrasted with individuals not known to have mental disease (pathological-"normal"). "Normal" individuals possessing particular attributes may be compared to "normal" individuals not having these attributes (an example of "normal"-"normal" control). In theory an attribute cannot be assigned exclusively to a particular group unless all conceivable other groups have been tested. In practice, of course, this cannot be done, so that in this case the exclusiveness of an attribute is always relative and never absolute. It is also true that the universality of an attribute in a particular group can only be relatively demonstrated, since other schizophrenics under other conditions (of climate, diet, physical or psychosocial conditions) might not possess the attribute. If, however, the main parameters previously discussed are adequately described and the controls are adequate, the value of the work will not be nullified by findings of deviations under other conditions.

It will be noted that the word "normal" has always been enclosed in quotation marks here, since the meaning of this word in psychiatric research requires detailed examination. This has been the subject of a separate paper which is at present in preparation. The obvious problem resulting is how to select a representative sample of a "normal" population when the attributes of the total aggregate which the sample is to represent are not known. This, however, does not constitute a real problem if the properties or procedures investigated are in respect to a particular pathological group whose attributes can be determined or at least defined. One could speak with reliability of the attributes of schizophrenics hospitalized in Rockland State Hospital at a particular period (approximately 4,000 patients). To determine even the simplest attributes of the non-hospitalized population in the New York area from which these patients are drawn would be fantastically difficult (over eight million persons).

This means that representativeness can be determined for the test group but not for the control groups. Since the control groups are selected on the basis of comparability to the test group in respect to extra-clinical attributes (physical and psychosocial) it would be extremely unlikely in any case that such a group would also be representative of the larger aggregate from which it was drawn. In special cases it is sometimes possible to develop controls which are both comparable to the test group and representa-

tive of the larger aggregate from which they themselves are drawn.* For ordinary purposes, however, this is a wasteful and time-consuming procedure.

One final caution is offered, namely, that attributes of a group (whether pathological or normal) selected on the basis of their comparability to a particular test group cannot be used to provide even reliable observational data about the control group. For example, it may be found that a control group of manic-depressives selected on the basis of comparability to a test group of schizophrenics in respect to extra-clinical characteristics might all have hypervitaminosis Q. One could conclude nothing about the relationship of vitamin Q to manic-depressives since the sample observed was not known to be representative of the total population of manic-depressives. One would have to select a representative sample of manic-depressives and repeat all the foregoing procedures to determine the relationship of vitamin Q to the manic-depressive psychosis.

"Observational" vs. "Experimental" data. In accordance with Boirac's paradigm for the scientific method, the four stages of research consist of: (1) observation, (2) hypothesis, (3) experiment, (4) deduction and conclusions. The simple finding of relations is, at the first stage (observation), either for the purpose of conceptualizing the nature of the group or for evaluating the effectiveness of a procedure. Such findings of relatedness are the *beginning* of scientific knowledge and not the final product. The unfortunate tendency to accept the finding of such relations as "experimental" rather than "observational" data has curtailed many a potentially valuable piece of work. The elaborateness of methods whereby observational data are obtained does not for that reason make them experimental data.

As an example of this research error let us gratuitously assume that a sample of hospitalized schizophrenics have been shown to have vitamin Q levels below the established normal range. This of itself is purely observational and not experimental data, and no conclusions can be drawn as to the existence of vitamin Q deficiency, either as an attribute of schizophrenics or as to the role of

*Representative samples of both groups are first selected. Then the comparable sample is selected from the control group on the basis of attributes within the test sample. The control sample thus obtained is then used to select patients from the test sample. At all stages representativeness of both groups must be maintained.

vitamin Q as a causal or determining factor in schizophrenia. It has been the discovery of such relationships and the acceptance of them as experimental data which has led to confusion.

After confirming the foregoing observation, the next step would be to hypothesize that vitamin Q deficiency is an attribute of schizophrenics in contrast to various control groups. The first control group used in the experiment might be one of nonhospitalized subjects not known to have any psychiatric disturbance and comparable in respect to extraclinical (physical and psychosocial) characteristics. The fact that none of such a control group have vitamin Q deficiency would constitute only a partial confirmation of the hypothesis. One would then set up a subhypothesis that vitamin Q deficiency was not related to mental disease in general, but limited to schizophrenia. The next control group might then constitute psychoneurotic subjects under treatment at an available clinic. The absence of vitamin Q deficiency in this control group would again be only a partial confirmation. The next subhypothesis might be that the vitamin Q deficiency was not an attribute of all hospitalized patients, but only of the schizophrenics. If it could then be demonstrated that hospitalized manic-depressives, alcoholics, arteriosclerotics and other groups did not suffer from vitamin Q deficiency a further partial confirmation would be at hand. The next subhypothesis might be that nonhospitalized schizophrenics also suffered from vitamin Q deficiency. (Note that this is an intergroup and not an intragroup comparison although the basic hypothesis is meant to refer to *all* schizophrenics.) If it could now be demonstrated that vitamin Q deficiency was equally prevalent in the non-hospitalized schizophrenics it might be reasonable to accept vitamin Q deficiency tentatively as an attribute of schizophrenics of the particular type studied.

One could definitely not draw conclusions in respect to vitamin Q as an etiological or causally related factor. The actual fact might be that a particular enzyme system was concerned as a causally related element in schizophrenia and that quite incidentally this enzyme disturbance resulted in vitamin Q deficiency which, of itself, had nothing whatsoever to do with schizophrenia. It would now be necessary, on the basis of the foregoing observation, to frame a hypothesis that vitamin Q deficiency was an etiological, precipitating, predisposing or perpetuating factor in schizophrenia and not a compensatory, resultant or incidental attribute. De-

pending upon the nature of the explicit hypothesis, an experiment would then be designed, using intragroup controls, in which procedures would be carried out relating to vitamin Q and its metabolism. The finding of negative results when the test group was given large amounts of vitamin Q in contrast to the control group would not by any means demonstrate that vitamin Q bore no causal relationship to schizophrenia. It might well be that vitamin Q was effective only when given in conjunction with potassium or some other agent. Regardless of how many negative demonstrations are obtained, there is never absolute evidence of the absence of a causal or effective relationship. Repeated failures to demonstrate effectiveness and satisfactory demonstration of different variables which fully account for the differences in behavior do, however, reduce the relative likeliness of the factor being an effective agent.

Because of the highly complex and constantly fluctuant behavior of organisms, even the foregoing method may prove to be only propaedeutic to developing methods for the selection of adequate samples and controls. Certainly much that is taken for granted in experiments in the physical sciences, because of the fundamental differences in the nature of the material being investigated, must be brought to light and re-examined in biological experiments. The formulation of adequate conceptual and methodological tools for the study of animate nature, and particularly biological organisms, has hardly begun.

Summary

1. Sample selection methods developed in the physical sciences cannot be directly applied to the study of deviant behavior: Individual differences cannot be totally neglected; motility and fluctuations of function must be taken into account; since "pure" samples cannot be obtained, methods for studying "in context" must be developed; and finally, the classification of material, upon which all science is based, is so tentative as yet in psychiatry that efforts must be devoted to developing a more adequate taxonomy, and safeguards against error must be maintained until such classes have been substantially established.

2. Samples should be representative of the population from which they are selected. This requires description and representativeness in respect to *all* important attributes and not just the diagnostic category. Methods and illustrations of how this can be accomplished are given.

3. Sharp distinction must be made between research that determines attributes or properties of classes (types of patients) and that which evaluates the effects of particular procedures on these classes. Demonstration of the existence of an attribute is not proof that it is causally (etiologically or therapeutically) significant.

4. There are three major methods of comparing (or "controlling") test results, each of which has its particular application:

(a) Intra-individual controls are suitable for use when the test sample is small, the variables largely unknown and the procedure to be tested is reversible.

(b) Intragroup (within group) controls are the method of choice for evaluating procedures and the only method of investigating irreversible procedures.

(c) Intergroup (between group) controls cannot be used to determine the effectiveness of procedures but are properly used to elicit the attributes of the group.

5. The difference between "observational" and "experimental" data is discussed, with emphasis on the fact that elaborateness of equipment and procedure does not transform the observation into an experiment.

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EDITORIAL COMMENT

TO YOUR VERY GOOD HEALTH

Don't stop us if you've heard this before; we think we have, too. We think we have heard it all before, and many times, too, in the days before, and in connection with, the Red Feather and the present country-wide community chest organizations for welfare agencies. But we should like to apply some observations that are by no means new to our voluntary health organizations—those dedicated to relief, prevention, education and research—as they are functioning today.

We, therefore, propose to discuss some aspects of our health groups' fund-raising organizations and functioning. We are not primarily, or even particularly, concerned here with the fellow who is always being asked to put his hand in his pocket to assist in the financing—although he serves very well indeed to illustrate. Our primary concern is with the health organizations themselves, the work they are doing, the educational task they are attempting, the general cause of a healthier America. We in psychiatry have a personal stake in the time and money and efforts we have invested in the National Association for Mental Health; and we have an important stake as citizens in a healthier nation generally. Besides our stakes as mental specialists and citizens, we have another as general medical people in the promotion of more healthful habits and more healthful ways of living.

We wonder if our presently discrete units in such fields as mental health, poliomyelitis and cancer are meeting our hopes and our intents in making our people happier and healthier. We wonder if they are functioning, not only for the best interests of those they serve, but for the best interests of themselves as organizations.

To spend a moment on the problem of contributions, we wonder if, through duplication of solicitation and multiplication of effort, we are not approaching the point of diminishing financial returns —if we have not, in fact, passed it. We wonder if, considering the health organizations as a whole, the multiplication of collecting, administering, technical and public relations staffs in half a dozen groups or more is not top-heavy and unduly expensive. We won-

der if—because as one solicitation follows another, the difficulty of obtaining contributions increases—we are not now compelled to spend more than should be necessary on the business of collecting, and so have less than we could well use for the actual work of our health programs. We wonder, too, if, with present methods, distribution of available funds is the best possible. When it comes to soliciting money, the first to come is not only the first served, he is likely to be the best served. If the tuberculosis and the heart associations come around first, they are likely to be served better than the cancer and mental health organizations coming later—and quite regardless of the relative needs of the groups. We suspect that if the various health associations could get together in something like community chest fashion, they might profit financially. We are perfectly aware, of course, that organizations who do not think so have blocked united fund drives in the past; we suspect conditions have now changed; and we think, even if they have not, that the time is past for selfishness!

We think some other than financial aspects are rather more important. If we fail to get funds we should have, or fail to make the best use of the funds we do get, we also fail to get all the co-operation we should have, or make the best use of the co-operation we do get. In any community, the numbers of the public-spirited who have both energy and ability to spare are limited. We think we are trying to spread too few of these people over too many organizations. If we round up some energetic organizers, good speakers and active students of their subject for the cancer organization or the mental health association, we may be depriving the tuberculosis and poliomyelitis groups of services which, in our particular community, they may need more. If we try to spread our few enthusiasts over several organizations, we are simply dividing membership time and interest to the point where no group at all will be served well.

This situation, we conceive, is also hampering our educational endeavors. The health crusader—in whatever specialty—must, among other things, employ established media for publicity, newspapers, radio and television, in any campaign for membership or public financial support. Any newspaper editor can pile a wastebasket high daily with publicity offerings in support of worthy causes. He can select a few—almost at random—for publication

with moderate space, or attempt to make bare mention of many; but a great many more will land inevitably in the yawning wastebasket. Groups with the best volunteers in the business of public relations, or with the best professional services, are likely to fare better in the scramble than the less well-served, quite regardless of the relative worth of their causes. The radio situation is parallel, with the radio program director often having to be even more selective in what he presents than is the news editor. And the business of commanding television attention may be more difficult still. We think this sort of thing means too little information, poor information, even misinformation, for the people we are trying to reach. We are failing to tell anything to a great many people and are failing to tell very much to a great many more.

Centralized handling of health educational material would, we think, get much more of it before the public—by avoiding editorial wastebaskets—and benefit the public health that much more. We think, too, that co-ordination of health association efforts should assure us of progress without relying on the adventitious circumstance which has provided major campaign impetus in the past; as, for instance that a president of the United States had been crippled by poliomyelitis; or, in a more circumscribed area, that a child with cerebral palsy, was able to dramatize the plight of other child victims by becoming an eminent medical specialist in his own disease. We should be intelligent enough to prepare ourselves, we think, without having to wait for eminent victims or exploits of personal heroism to dramatize any threat to health in general. With an alert, co-ordinated public health effort designed to cover the total field, we think we could combat the less dramatic, but no less real, among the health menaces more successfully.

Proper co-ordination could mend defenses which, like the 1940 Maginot Line, could not only be turned but have plain gaps in them. We cannot expect organizations formed and adapted to fight cancer and tuberculosis to meet a new and different menace (which might arise at any time through mutation of a virus or a bacterium) adapted to sweep around our flank like a tank column through Belgium. Or we cannot expect our present health education measures to meet currently-controlled dangers gone presently out of hand, as by sudden multiplication of penicillin-fast gonococcus or treponema pallidum. But with the health groups united

and prepared to act where needed, new menace would automatically bring new defense. And if some of our problems were suddenly solved; if, for instance, cancer, poliomyelitis or tuberculosis were suddenly to be disrated from the rank of killer to that of minor nuisance—and we know that while this is unlikely it is not inconceivable—effort and organization no longer needed for a specific purpose could be turned readily to another. With today's discrete organizations, a group with its special health problem neatly solved would be simply homeless, its further efforts wasted.

We think also that co-ordination of our efforts would do us, as specialists, the people we seek to interest as workers and organizers, and the public we seek to educate, more than a minimum of good. As it is, we are all too prone to attach disproportionate importance to our own fields. Medical people are human; and, if the legendary breakdown into right-eye and left-eye specialists ever could occur, we have no doubt they would battle bitterly over which was more important than the other. For our own sins, which are manifest and manifold, we may note that a recent medical writer has chosen *It's Not All in Your Mind* for his new book's title. However inescapably necessary extreme specialization may be, it is bad for the sense of proportion which is a basic objective of all good education, including our own; and it can be a source of wide distortion in any health campaign addressed to the public at large.

Those who have borne with us thus far are invited to draw their own blueprints. We haven't gone that far and don't intend to. We do think any such co-ordination or consolidation should not be controlled by professionals; and we think the work of organization will likely be a slow process—and maybe ought to be a slow process. We think the thing is vastly complicated also by the national organization of the health groups.

Many of the organizations now supported by community chest campaigns are strictly local to their own communities—most voluntary hospitals and settlement houses, for example. Many others, a YMCA, for instance, may be organized nationally but, in relation to community activities, supported strictly locally. The mental health, tuberculosis, cancer and other health groups are national associations. To federate or unite on a community basis, it might be necessary to federate or unite on a national basis; and we have already made note that this may be difficult. We know

of individual community amalgamations of two or more groups, in some cases apparently working well, in others abandoned after valiant attempts. And we are awaiting with interest the outcome of endeavors in some places to put present community chest and health organizations into consolidated "united funds." Perhaps if this sort of thing can be worked out here and there on a local basis, it will point the way to the general unification we have in mind.

Whatever we call it, and whether we retain temporarily or discard at once our separate organization titles, what we have in mind eventually is a community set-up in which all existing health organizations will function as united community associations, carrying on their present activities as sub-associations, committees of the main association, or subcommittees. It seems to us that there will be manifest present, and eventually great, advantages.

From the point of view of the mental health people, it is impossible to separate mental health from health in general. Factions among us have almost made a phrase of opprobrium of *mens sana in corpore sano,* using it as a reproach against proponents and opponents alike of organicism (whatever that means) as psychiatric theory. But in its orginal sense of healthy mind in healthy body, it represents a goal that we cannot well attain in fractions. A person is either healthy or unhealthy; why divide him into parts? The result is just as deplorable (and not vastly different) whether ill health is in a paralyzed limb, a deranged mind or a weakened heart. And we think we workers for health in one part or another, one limb or another, one function or another, would do well to recognize the reality and work for health as a whole.

We can see complications. Which tail is going to wag the dog? Or do we take turns? We see no reason for too great conflict on lines of specialization. It is true that we can always refer to the psychiatrist who misdiagnosed brucellosis as neurasthenia; but we also know of a cardiologist who diagnosed mitral stenosis as a cardiac neurosis. We think promoters of mental health ought to be able to work as well with other health groups as we can with ourselves, or as they sometimes do with themselves. We think mental health principles permeate other health problems all along the line; and other health principles *vice versa*; they permeate mental health problems all along the line—as any psychiatric social worker can stand up in meeting and loudly testify.

But if we see no reason for endless conflict, we see no reason either for anticipating a Swinburnesque path of co-operation lightened by the wine of optimism and strewn with thornless roses. We can see practical difficulties which will give people of the greatest goodwill the greatest trouble to work out. All the more reason, we think, for doing something about making a beginning. We know that both national and local attempts at this have failed before. We think they ought to be made again.

BOOK REVIEWS

Practice of Psychiatry. By WILLIAM S. SADLER, M. D. 1146 pages. Cloth. Mosby. St. Louis. 1953. Price $15.00.

Dr. Sadler has already written two textbooks, namely, *Theory and Practice of Psychiatry* published in 1936 and *Modern Psychiatry* published in 1945, but he advises in his preface that the textbook reviewed here is not revised from other issues but is rewritten. In rewriting he has brought his work up to date, and he has added several new features, one of which, is his section dealing with "Attitudinal Pathoses" (pre-neurotic disorders).

The book has seven parts: Part I, General Psychiatric Consideration; Part II, The Pathoses; Part III, The Neuroses; Part IV, The Psychoses; Part V, Personality Disorders; Part VI, Psychosomatic Disease; and Part VII, Psychotherapy. In addition, the book has an appendix in which the history of the theories of the various schools of psychiatry is given; it has a glossary which is equivalent to a psychiatric dictionary; it has a good bibliography; and last, it has a very good index.

This textbook should be very useful to students and general practitioners. It is a good textbook. It does have some defects, however. One regrets that the author has tried to coin new words and has classified and described mental illnesses according to his own style. In addition, he does not follow the new American Psychiatric Association classification of mental diseases, and it is not even mentioned in his book. At best, psychiatry is confusing to the student, and textbooks which vary too much from accepted standards do not improve the confusion.

Psychiatry To-day. By DAVID STAFFORD-CLARK. 304 pages. Paper. Pelican Books. London. Penguin Books. Baltimore. 1952. Price 65 cents.

To anyone in the fields allied to psychiatry this book will prove to be one of the best possible investments. While written for the intelligent layman, the extremely low price and the soundness and scope of the information contained open many possibilities for the book's utilization as a teaching tool. The format is rather monotonous, as is to be expected in a pocket-sized edition, but this is a minor matter. The coverage of the subject is very comprehensive, but better for the functional than organic psychoses. Technical and factual information is well presented—the essential data are given and dullness is to a large extent avoided. The author retains an objective attitude in his writing, though the general approach is essentially orthodox. The fact that the book was written in England in no way detracts from its value in this country—in fact, at times this reviewer thought it an advantage.

The Second Sex. By SIMONE DE BEAUVOIR. 732 pages. Cloth. Knopf. New York. 1953. Price $10.00.

The widely publicized book of the female French existentialist is best characterized by two rhetorical questions: "How naïve can one be?" and "Isn't it probable that if someone dared today to revive du Maurier's writings on Trilby-Svengali (1894), he would be laughed out of literary existence?" Still, Simone de Beauvoir's thick volume is but a revival of the old feministic literature of the 60's, 70's and 80's of the last century, making out of man the malefactor who subjugates the "second sex" à la Svengali. In Mme. de Beauvoir's case, Svengali is social custom and a mysterious fear of "the Other," whatever that may mean. Save for a few existentialist and Marxist trimmings (the latter gallantly overlooked by the host of enthusiastic reviewers), this anachronistic book could have been written nearly a century ago.

The sober fact is that what the author has to say in 732 pages, can be condensed into a few words: Man enslaves woman. Everything else in the volume is but wrapping paper, including amateurishly used biological, historical, literary, and sociological material. The book is boring, loquacious, repetitive, and especially quarrelsome, even to the point of mildly suggesting mild paranoid ideas. The author is pitifully disoriented about modern psychiatric-psychoanalytic findings. Her main authority is Stekel; when she refers to Helene Deutsch, she mostly misunderstands; her polemic with Freud is based on ignorance of his later findings on pre-Oedipality.

Time and again, the sex act is described as cruel aggression against poor woman; Mme. de Beauvoir completely ignores the fact of neurotic passivity in men; as Karl Menninger aptly remarks, "Every psychiatrist sees a dozen women complain of the passivity, dependence, and/or impotence of their husbands to one who complains of his ruthlessness."

The book is impressive only in its mass of misunderstandings. To name a few: The author misunderstands the oral phase; the Oedipal phase is changed to unrecognizability; the difference between clitoridean and vaginal orgasms (though mentioned) is misinterpreted; Lesbianism and prostitution are misconceived—in popular terms; the whole problem of neurotic fears is widely distorted.

More dangerous is complete misunderstanding of motherhood: "There is nothing natural about maternal love. They [mothers] are permitted to play with toys of flesh and blood" (p. 523).

And the solution during the transitional period to a happier state? Although the author is unclear on that point, one gathers the impression that some kind of promiscuity is half-suggested; some passages in the last chapter, especially on pages 686 and 687, give this impression, when the situation is regretfully noted that "to enjoy the relaxation and diversion provided by agreeable sexual adventures" is not so easy for the woman.

"Her situation in this respect is not equivalent to man's." Or, if the demand of some women "for brothels for females," staffed with "taxi-boys," is discussed, it ends up with the statement, "At any rate, this resource is unavailable."

Ironically, where the author has a case, she does not see it, or is uninformed about scientific findings. There is no doubt that the typical man has a supercilious attitude toward woman, based on the narcissistic defeat of having been, once upon a baby-time, completely dependent on a woman. Bergler described in *The Basic Neurosis* the compensatory "hoax of the He-Man," and showed that by using the "unconscious repetition compulsion" (Freud), denoting active repetition of passively endured experiences to restore the lesion in his narcissism, the boy reverses the roles of active mother and passive child. By unconsciously identifying breast and penis, vagina and mouth, milk with urine (later sperm), the man acts in intercourse as the active "mother," reducing the woman to the baby—the image of his own infantile self. This is also the reason why man calls woman—"baby." This compensatory attitude unconsciously colors man's whole attitude toward woman. Finally, all the Grand Guignol of infantile fears (enshrined in the unconscious) is counteracted by proving to himself that "woman is too weak to be dangerous." Here is the real case that the author of *The Second Sex* fails to see.

To sum up: *The Second Sex* is scientifically a complete nonentity, based on ignorance and prejudice. However, the combination of naïve popularization plus sex, seems irresistable for immature critics and—readers.

Psychological Problems of Cerebral Palsy. 79 pages. Paper. Published by The Easter Seal Society. Chicago. 1952. Price $1.25.

This publication is the proceedings of a symposium on cerebral palsy sponsored on August 20, 1951 by the National Society for Crippled Children and Adults, and the Division of School Psychologists of the American Psychological Association. A well-rounded selection of papers by authorities in the medical, psychological, and educational aspects of cerebral palsy is included. Research material is presented, and discussions of each paper are also included. The first of the five papers comprising this symposium is on the anatomical facts related to spasticity, by Douglas Buchannan. Charles Strother, professor of clinical psychology, University of Washington, presents the next paper on the psychological aspects of cerebral palsy; Harry Bice presents "Group Counseling with Parents of the Cerebral Palsied"; Edgar Doll's paper is on the "Distinction between Neurophrenia and Cerebral Palsy"; and the final paper is on "Educational and Vocational Planning for the Cerebral Palsied Child" by T. Ernest Newland. A summary by Dr. Doll rounds out the symposium. The papers and the discussions are, for the most part, well presented, and this publication is recommended for those interested in the area of cerebral palsy.

Psychology of Physical Illness. Psychiatry Applied to Medicine, Surgery and the Specialties. Leopold Bellak, M. D., editor. 236 pages. Cloth. Grune & Stratton. New York. 1952. Price $5.50.

In his introduction the editor states, "We offer this book with the hope that we may contribute to a better medical practice—one which is more enjoyable for the doctor and more beneficial to the patient.

"The chapters of this book are so organized as to primarily present the psychological implications of the medical-surgical disorders of each field. Secondarily, the psychogenic aspects of somatic complaints are discussed for convenience of organization and because psychosomatic and somatopsychic problems often interact.

"Each chapter is written by authors with experience in both the medical-surgical specialty and psychiatry. By this means we hope to present not irrelevent theory, but practical useful data by men with real experience."

In most cases, neuropsychiatrists are well acquainted with emotional problems which are expressed in somatic symptoms, but such is not the case with most general practitioners and many specialists. The book, therefore, seems to be directed to these particular medical men. In it, psychiatric problems associated with internal medicine, surgery, obstetrics, gynecology, genito-urinary medicine, orthopedics, pediatrics, dermatology and dentistry are presented especially well. In addition, a chapter reminds the physician that his own personality is an important factor in therapy.

Our Common Neurosis. Notes on a Group Experiment. By Charles B. Thompson, M. D., and Alfreda P. Sill. 208 pages. Cloth. Exposition. New York. 1952. Price $3.50.

The late Dr. Trigant Burrow was probably one of the first to experiment with what is now called group therapy. Many of his opinions were molded by research projects such as has been recorded in this book by two of his co-workers. What Dr. Burrow called "phylobiology" refers to a study of the "whole" man, psychologically and physiologically, under the influences of society, with its customs, its teachings, its moral and social philosophies and its inconsistencies of behavior.

The co-authors state that each human being is abnormal in his individual manner and that every person suffers from a "common neurosis" created through social unrest, disguise, deceit and selfishness. "By turns aggressive and timid, but continually preoccupied with his own prestige, man is impelled to fight by an obsessive urge he has never tried to understand. A phylo-organismic interpretation of behavioral conflict demands that we abandon the solemn farce . . . and adopt an immediate, internal, societal approach to man's disordered behavior. It demands that we turn aside

from the fascination of this or that external circumstance, this or that moral judgment, and face human conflict as a problem internal to ourselves as a race or species."

The book contains 53 sketches and essays written about 1923 by students who became members of a research group and who, in their writings frankly expressed their own personal conflicts as they might do in what one now calls group therapy. The co-authors, Thompson and Sill, have spaced this material along with their own opinions in such a way that the book is interesting and very informative.

Treatment of Mental Disorder. By LEO ALEXANDER, M. D. 490 pages. Cloth. Saunders. Philadelphia. 1953. Price $10.00.

Dr. Alexander is well known for his studies of neurophysiology and neuropathology and, more recently, for his work in psychiatry. He is now director, The Neurobiological Unit, Division of Psychiatric Research at Boston State Hospital.

Dr. Alexander credits the common forms of psychotherapy with many successes and, in his book, reviews and discusses these therapies but he calls special attention to the fact that ". . . a fourth group of psychiatric workers is starting to emerge and is approaching the problem from three angles; first, in a concern with the scientific investigations of the basic principles involved in the new methods with an attempt to understand them against the background of neurophysiologic knowledge, correlating them with the established facts and scientific principles of neurophysiology; second, in a study of the actual direct consequences of these methods on the patient in the light of our knowledge of the integration of higher cortical activity—for which I should like to use the term, *psychophysiology*, and third, in attempts to test and investigate the interrelations between these newly discovered psychophysiologic phenomena and the body of psychodynamic knowledge. It is to these attempts that this book will be especially devoted."

In his somatopsychic or psychophysiologic approach to the treatment of mental illness, the author relies heavily upon what he calls "the Funkenstein Test" to determine what type of physical therapy he is to use. This test was developed by Funkenstein and his co-workers in a study of the mental "patient's psychic and autonomic reaction to two drugs with opposing effects on the autonomic nervous system—*epinephrine*, which with its adrenergic effect may serve as a measure of sympathetic reactivity, and *mecholyl* (acetyl-beta-methylcholine, methacholine), which with its cholinergic effect may serve as a measure of parasympathetic reactivity, or rather as a counterbalance of sympathetic reactivity. In the test devised by Funkenstein and his co-workers for this purpose, he uses the systolic blood pressure as a measure of autonomic reactivity to each drug after the

basal blood pressure level has been established, determining the intensity of response and the ability to re-establish homeostasis."

It seems that the reactions to these drugs fall into six groups and that the type of reaction will predict the type of physical therapy which is best to use and the probable prognosis. The author has apparently used this method extensively, and he reports obtaining good results. In describing his methods, he includes brief case histories with graphs showing the "Funkenstein Test" reactions before and after treatment. The forms of physical treatment which he uses are, mainly, convulsive electric treatment, nonconvulsive electric treatment, electric stimulation, insulin shock and a combination of two or more.

This book will be especially valuable to those who are starting to use the various forms of physical therapy. The author describes the types of electric current, the various methods used and the equipment necessary. He spends several pages describing use of the Teiter equipment for nonconvulsive therapy.

In addition, Dr. Alexander describes the complications which may arise in the use of physical methods; discusses the neuropathological aspects; reviews his results and those of others who have used these forms of therapy; describes the role which the nurse must play; and reviews the treatment of alcoholism, drug intoxications, and organic cerebrospinal diseases.

Social Treatment in Probation and Delinquency. By PAULINE V. YOUNG, Ph.D. xxvi and 536 pages. Cloth. McGraw-Hill. New York. 1952. Price $7.00.

This book will be found of primary interest to those in the fields of child welfare and sociology, rather than to those in psychiatric work. The sections dealing with such matters as the Rorschach Test are elementary in approach. A great deal of individual case data is included, and a very comprehensive survey of the field is given. The value of the book to social workers and child guidance workers should not be underestimated.

Las Pruebas Proyectivas y el Conocimiento de la Personalidad Individual. POR MIGUEL SIGUAN. 116 pages. Paper. Departments de Psicologia Experimental Instituto Luis Vives. Madrid. 1952. No price stated.

A psychologist in Spain offers a descriptive pamphlet on the Rorschach examination and Thematic Appereception Test. All of the work is a direct translation of source material. There is no indication that the tests are being used for experimental, standardization or diagnostic purposes in that country.

Famine Disease in German Concentration Camps: Complications and Sequels. Acta Psychiatrica et Neurologica Scandinavica; Supplementum 83. By PER HELWIG-LARSEN, HENRIK HOFFMEYER, JOERGEN KIELER, EIGIL HESS THAYSEN, JOERN HESS THAYSEN, PAUL THYGESEN, MUNKE HERTAL WULFF. 460 pages. Paper. Ejnar Munksgaard, Copenhagen. 1952. Price Dan. kr. 35.00.

The effects of prolonged starvation upon the human body and personality have been studied by many groups, but until the experiences of the last war there had not been a situation where effective research could be conducted. The condition of Danish internees was not typical of German concentration camp inmates, but this in no way invalidates the observations made in this book.

The chief difference to be found between the conditions in the German and Japanese prison camps was the fact that in the German camps the chief deficit was in *quantity* of food, while in the Japanese camps it was in *quality* of food. Thus, the cases of avitaminosis so prevalent in the Japanese camps were rare in the German camps—in all too many cases the internees in the German camps starved to death before the symptoms of avitaminosis had time to appear. During this starvation regime, acute psychiatric symptoms were a rarity—the usual effect being, rather, a complete dulling of the mental faculties.

The aftermath of this type of experience on the internees has been a very prevalent neurasthenic syndrome—occurring to greater or lesser degree in the majority of those interned. Psychoses following the experience were a rarity—there were few cases, even if those committing suicide are considered in the psychotic classification. The authors put forward their views well, but in no sense dogmatically; full recognition is given to the fact that the men making the study were not psychiatrists but medical doctors, who, through circumstances, were present at the time.

The Origins of Intelligence in Children. By JEAN PIAGET. xi and 419 pages. Cloth. International Universities Press. New York. 1952 Price $6.00.

The work of Piaget is too well known to need further introduction. This book records his researches concerning the factors that originate intelligence in the child. Intelligence is held to be: "the development of an assimilatory activity whose functional laws are laid down as early as organic life and whose successive structures serving it as organs are elaborated by interaction between itself and the external environment." This is most definitely not a book for the casual reader—only a person deeply interested in the subject will have the tenacity to follow the author through the maze of his researches and thinking.

Lives in Progress. A Study of the Natural Growth of Personality. By ROBERT W. WHITE. v and 376 pages. Cloth. The Dryden Press. New York. 1952. Price $2.90.

The author intends this book as a brief introduction to the field of personality. There is an attempt to understand and examine, by methods which are described, the life histories of three normal persons. The author first makes a short survey of the various theories which have contributed to our knowledge of personality—biological research, especially that in learning; dynamic psychology; and the social-cultural approach. In the case studies which follow there is constant interpretation of the life history and test data in terms of these various points of view, as well as generalizations about the behavior of man.

Intervening chapters are concerned with the methodology of the study, the effect of social forces upon the subjects' lives, and the biological roots of personality. When the three case histories have been discussed in detail, White then sets forth what he calls the psychodynamics of development. This is primarily a critical evaluation of the Freudian theory in terms of its utility in contributing to the understanding of the three individuals studied. The concluding chapter presents the author's thoughts on the process of natural growth. Here is stressed the fact that the individual responds selectively to the environment. He is active and cannot be considered a passive, helpless and static organism.

How to Understand Propaganda. By ALFRED M. LEE. xii and 281 pages. Cloth. Rinehart. New York. 1952. Price $3.00.

The techniques employed in influencing people have been refined to an extraordinary degree. By turning the switch on a television set, one can see any number of devices used—be they to gain votes or to change the brand of your toothpaste. The author, in studying the subject of propaganda, has brought to the task a good knowledge of psychiatric concepts, which he utilizes when the occasion warrants it. It is interesting to note that this book, which deals with propaganda, could, because of the choice of subject matter, be accused of being "liberal" propaganda itself.

The Lovers. By KATHLEEN WINSOR. 362 pages. Cloth. Appleton-Century-Crofts. New York. 1952. Price $3.50.

The Lovers consists of three novelettes. Each of the stories has a theme of love—love, in its most primitive form. To add intrigue, the author introduces symbolism and the supernatural. Why she bothered with the latter concepts, one will never know. She lacks ability for the abstract, has little imagination and underneath the verbiage it's still pretty much of the same *Amber*.

Navaho Religion. A Study of Symbolism. By GLADYS A. REICHARD. Bollingen Series XVIII. 2 Vols., 800 pages, including index. Cloth. Pantheon Books. New York. 1950. Price $7.50.

Students of abnormal behavior are past the stage when they have to be converted to the tremendously suggestive value of ethnographic data. The many bridges built by Freud, Róheim, Kardiner, Erikson, Devereaux and others have made the communication between dynamic psychiatry and cultural anthropology easy and fruitful. Thus, it is only too natural to look at every new collection of anthropological field data with reference to their potential value for research and theorizing in psychiatry.

Viewed in this light, Gladys Reichard's two-volume study of Navaho religion is somewhat frustrating. It contains enough insights into Navaho attitudes toward death and human destiny, disease, diagnosis and therapy, supernatural monsters and protectors, sex morals and the concept of honor, to make one want to learn more about the complex inner life of this human group. The author, who is a life-long student of the Navaho and could be presumed to have a wealth of first-hand observations, never goes beyond tantalizingly brief references to specific cases, and thus leaves one with a feeling of dissatisfaction. In a sense, this work could be considered a collection of leads for anyone with the desire and the means to do an intensive study in this largest and culturally best preserved of Indian groups.

The Bollingen Series to which this book belongs is usually associated in our minds with the Jungian school of psychology. Professor Reichard's dryly academic study bears no trace of this school's impact.

Personal and Social Adjustment. By WAYLAND F. VAUGHAN. 578 pages. Cloth. Odyssey Press. New York. 1952. Price $4.25.

This text, the author asserts, differs from other textbooks on mental hygiene in that it deals chiefly with normal people rather than abnormal. It is oriented around the concept that mental disorders are essentially disturbances in social relations. It tries to show how love and hate affect our human relationships for better or worse.

This text provides a rather wide range of topics covering diagnostic and therapeutic techniques, and discusses the contributions of Horney, Adler, Jung, Freud and others. In addition there are excellent presentations of the history of psychotherapy; the techniques used by psychoanalysts, projective tests "as x-ray procedures," the role of semanticists, the contributions of Alcoholics Anonymous, accomplishments in psychodrama, and discussions of the mental health problems of infancy, childhood, adolescence, adulthood, middle age and old age.

This book is extremely easy to read, with its many illustrations, cartoons, and frequent use of humor, and it should provide an excellent college text for beginners in the study of mental hygiene.

How I Cured My Ulcer. By JOHN PARR. 153 pages. Cloth. Little, Brown. Boston. 1952. Price $2.75.

One might say that the author is "scooping" the doctor and the authorized medical journals. He gives one the impression that he is so happy to have been relieved of his ulcer that he wants "the world to know." Perhaps one cannot blame him. At any rate, the author gives a somewhat tragic, yet amusing account, of his experiences in seeking a cure for his gastric ulcer. He tells of the various doctors (fictitious names are used) he consulted, their explanations and their methods of treatment. He states that he consulted a Dr. Spira who had concluded that it was not hydrochloric acid, etc., which caused ulcers but that they were due to a hypersecretion of bile. Because of this, the doctor gave him some alkalies to relieve his pain, but the special therapy was a fat-free diet. Milk, cream, fatty foods, etc., were all forbidden.

The author states that the doctor has proved this method of treatment to be the correct one and that articles written by the doctor will soon appear. Everyone hopes that all of this is true and that, at last, gastric and duodenal ulcers can be easily cured.

Psychology in the Service of the School. By M. F. CLEUGH. 183 pages. Cloth. Philosophical Library. New York. 1951. Price $3.75.

This text is written for parents, teachers, welfare officers, probation officers and others interested in problems of childhood. There is a minimum of technical language and a large number of examples.

The author discusses in detail different types of children's problems, analyzes their causes, and makes suggestions for better understanding of the difficulties. Problems discussed include: judgments and misjudgments, meaning of maladjustment, fight and flight, handling of aggressive reactions, and handling of regressive reactions.

The text is well written but very superficial, even for a layman. The title of the book is misleading, in that school psychology, as we know it today in America, is a more highly developed procedure than this book might indicate.

By the Waters of the Danube. By ALEXANDRA ORME. 360 pages. Cloth. Duell, Sloan & Pearce. New York. 1951. Price $3.50.

This novel is about Hungary and Poland in 1945, immediately after the end of World War II. A mass of frightened humanity, pressed into the Soviet orbit, is depicted; the tone is sometimes flippant, sometimes ideologically confused, frequently intermingled with grim humor. The author seems to describe her own experiences; she has no idea how a book is written, although sometimes she manages to convey a remarkable picture of human derelicts.

History of American Psychology. By A. A. Roback. 403 pages. Cloth. Library Publishers. New York. 1952. Price $6.00.

This is probably the first popular-styled history of American psychology. It is, naturally, very factual and documented but it is also easy and pleasant reading. It is the type of book which will be very helpful to the student. It will be especially good for college libraries.

Part I begins with colonial days; follows through the periods when psychology is trying to be recognized as a separate entity in the world of science; describes the Scottish and the German influences and the gradual transition period during the 1880's.

Part II covers the subject, "Psychology Comes of Age." The new psychology, as Dr. Roback states, became a psychology of experimental methods of teaching; and became a specialty with a language of its own, divorced from religion and philosophy. This part of the book also gives brief but very informative and, at times, very amusing biographies of such men as William James, G. Stanley Hall, George Ladd, J. Mark Baldwin, J. McKeen Cattell, Edward B. Titchner and Hugo Münsterberg.

Part III describes and elaborates upon the various "schools" of psychology.

Finally, in Part IV, Dr. Roback looks to the future and to the phenomenal advance of American psychology.

Marriage. By Kenneth Walker. 136 pages. Cloth. British Social Biology Council. Secker and Warburg. London. 1951. Price $2.00.

This book is intended for both married and about-to-marry couples. It aims to provide information and guidance essential to building a successful marriage. There are such topics as: choice of a partner, courtship, preparation for marriage, sexuality in marriage, anatomy of the male and female sex organs, the nature of the sex act, difficulties arising on the wedding night, frequency of intercourse, and sexual needs of both partners.

In addition, there is a chapter on family planning which includes discussions of contraceptive methods, spacing of pregnancies, absence of children, adoption and artificial insemination.

As a whole, the text is well written, covers a wide variety of important topics, and clearly presents its material in an interesting, informal, nontechnical manner.

The Adopted Family. By Florence Rondell and Ruth Michaels. 80 pages. Cloth. Crown Publishers. New York. 1951. Price $2.50.

The Adopted Family is a well-meaning, naïve presentation in two parts: a guide for adopted parents, and material for reading to the child. External problems are optimistically described; the psychological implications, however, are nearly completely omitted.

Errors of Psychotherapy. By SEBASTIAN DE GRAZIA. 236 pages. Cloth. Doubleday. New York. 1952. Price $3.00.

During the last few years one has noted a gradual breaking away of many practitioners from psychoanalytic theories of causation and methods of treatment of mental illness. One might call it a swing away from amoral theories to moral theories. Perhaps it is hard to say just who started this swing but many will probably give credit to Harry Stack Sullivan. At any rate, this change is well worth consideration since it seems, to many, a more understandable, a less involved and, perhaps, a more human approach to the understanding of mental illness, particularly of the neuroses. Everyone who has studied mental illnesses and has tried to treat them has recognized many errors, but the human mind is a complex mechanism, and one tends to hesitate to condemn aggressively any of the theories set forth in the last 50 years. One may hope that the present swing is the one that will give the answers, and yet may wonder if therapy will be easier to accomplish.

Dr. de Grazia has written a very interesting book which should be read by all persons whose professions deal with emotional illnesses. His *Errors of Psychotherapy* refers to an approach to the understanding of mental illness rather than to a method of therapy. He criticizes the lack of unity among the secular schools of psychotherapy and the failure to recognize the moral factors causing mental illness. The author holds that neurosis is a moral disorder. "The persons who come to the psychotherapist are all fired in the same crucible. They have thought bad things or done bad deeds, and so they suffer, ground and baked in a hot oven, cooked, no less, in their own galled conscience."

Dr. de Grazia believes that each person has grown up emotionally under the guidance of an authority (mostly parental) and that—because of this—the neurotic, when seeking help, seeks a substitute authority, the therapist, who, through his methods of listening to the patient's problems, can, if he is not careful, make serious error and, thereby, lessen his authority and fail in therapy. The author reminds the reader that, as one listens, such expressions as "uh, uh-huh, m-hm, uhn-uhn" may greatly influence or disturb the confidence of the patient in the therapist. "With the sounds decoded, the moral judgment appears. . . ." The patient gets an idea of how the therapist reacts, approves or disapproves, agrees or disagrees, is shocked or not shocked. ". . . moral authority, an idea widely spurned by modern healers of the soul, is the crux of psychotherapy. The crystals that remain after distilling the multiplicity of therapies are not many. A bewildering array of brilliants dwindles down to a precious few: Neurosis is a moral disorder, the psychotherapeutic relationship is one of authority, the therapist gives moral direction."

The author calls attention to another "error" of modern psychotherapies. He states that the patient's moral problems (what are right or wrong for the patient) are minimized by the therapist; that what, to the patient, is wrong is not to be ignored since what he is seeking is not a method of ignoring his problem but a method of obtaining forgiveness. "Take each school of psychotherapy separately; it is a redemptive system, designed to relieve guilt. Take them together; they are a snarled mass of conflicting moral teachings. Take them separately, tune them together like the strings of a lute, harmonize their knowledge and ideals; they become religion."

Taken as a whole, this book is a very provocative one and, although many will severely criticize it, it should receive respectful consideration.

The Heart of a Man. By GEORGES SIMENON. Translated from the French by Louise Varèse. 213 pages. Cloth. Prentice-Hall. New York. 1951. Price $3.00.

The Heart of a Man tells about the life and—in detail—the loves of a famous actor, after his doctor has informed him that he has a heart disease and only a short time left to live. The morbid atmosphere of the chief character's experiences may be depressing and plain "scary" for some readers. It may be relaxing because it provides escape for others, as the reader will be completely absorbed by the novel. Whichever the experience, the reader will admit it's a book that's hard to put down, morbid and mysterious to the finish.

It will be up to a later generation of psychologists and critics to find out why so many of our professionals find mystery novels appealing and relaxing. Simenon's novels, this reviewer feels, certainly will make good specimens of the successful mystery novels of the 1950's.

Conflict and Light. Studies in Psychological Disturbance and Readjustment. Père Bruno de Jesus-Marie, O. C. D., editor. Translated by Pamela Carswell and Cecily Hastings. 192 pages. Cloth. Sheed & Ward. New York. 1952. Price $2.75.

This book is a collection of papers published originally in French under the editorship of Père Bruno de Jesus-Marie, O. C. D., director of *Études Carmelitaines* of Paris. They were written by psychiatrists, other doctors and priests, all of whom express belief in a moral theory of behavior and of mental illness. They describe the various types of sin, the misinterpretations of sinfulness, the sense of guilt, the false sense of guilt acquired by children, the interpretations of morality, the psychological aspects of conscience as seen in mental illness, and the psychological benefits of confession. Some parts of the book become involved in theological language but, generally, one might say that the ideas expressed will be considered sound theoretically.

The Mystery of Hamlet King of Denmark or What We Will. By PERCY MACKAYE. xiii and 676 pages. Cloth. Bond Wheelwright. New York. 1950. Price $6.50.

These four plays form a prologue to Shakespeare's *Hamlet* and strive to give the reader the events leading up to that play. Much use is made of mysticism—events in *Hamlet* being foreshadowed in these plays. The first act of *Hamlet* is used as the last act of this tetralogy. It is of course unfair to use the original as a comparison, but the subject invites it. In this sense, the chief thing that Percy Mackaye lacks is a feeling for the dramatic—he is unable in just a few words to make a situation apparent. The poetry cannot be called an imitation of Shakespeare; it is rather the poetry of another man written somewhat in the style of Shakespeare. As poetry, however, it can stand on its own feet, rising to brilliance only occasionally, but at the same time seldom descending into mediocrity.

Those looking for an explanation of the inner drives of Hamlet will not find it here. While in plays as allegorical as these almost any interpretation could be made (as indeed they can be in Shakespeare himself) there is no strong backing for any of the analytical theories concerning Hamlet —such as an extremely strong Oedipus complex. It should be stated that this book is one of the finest pieces of typography this reviewer has encountered recently, something especially remarkable in a book this large at the price at which it is sold. It would be almost worth while to obtain the book as an example of the art of bookmaking alone, though there is more than that to recommend it.

The Correspondence Between Paul Claudel and Andre Gide. 299 pages. Cloth. Pantheon. New York. 1952. Price $4.00.

When the correspondence of a literary figure is published, the usual fault to be found is the lack of background material and the fact that the correspondence has little to offer to the general reader, as it does not have sufficient literary or historical value to make a book of interest to those not close students of the man or his times. These faults are not to be found in this collection. Every effort has been made, by including selections from the *Journals*, etc., to provide the reader with clues as to the thoughts and actions of the writers at the time of writing the letters.

Gide was a man who was continually searching for—searching for and never finding—a set of guideposts. These letters deal with long, sporadic, and unsuccessful efforts of Paul Claudel to convert him to Catholicism; and they show the evolving of Gide's thoughts through the years. They end at the time when Claudel reluctantly concedes to himself that his efforts have been unsuccessful—that Gide lived by a set of religious ideas and sexual mores that were antagonistic to his own.

The Untouchables. By ALFRED MAUND. 32 pages. Paper. Southern Conference Educational Fund, Inc. New Orleans. Price (in quantities) 50 cents a pamphlet.

This is an ably and indignantly written pamphlet, written by a native Southerner and illustrated by the drawings of Ben Shahn, on the subject of racial segregation and discrimination against the Negro in American hospitals. The statistics quoted and most of the material cited are from Southern or border states and the District of Columbia, although one New York City and one Chicago incident are mentioned. Its publishers announce its purpose is to combat segregation. It is worth the attention of any person concerned with hospital problems, particularly with those of general hospitals; but just how much application it has to the North, or even how accurately it reflects the situation in the South, is difficult to judge. It also shares a common fault of publications of this kind; places where there is no discrimination whatever—like the hospitals of the New York State Department of Mental Hygiene—are unmentioned; and a careless reader is likely to conclude that the practices complained of prevail generally.

Prescription for Marriage. By MARY BRINKER POST. 233 pages. Cloth. Messner. New York. 1952. Price $3.00.

This text is a psychological novel dealing with what the author feels is the most significant and rewarding relationship in life—marriage. "Companionship, tenderness, understanding, and especially passionate, mutually satisfactory sexual love create so important a relationship that a woman should hold on to it stubbornly, no matter how deeply shaken she may be by disillusionment." The author writes this conviction into her story of Laurie and Martin Joyce. Laurie felt the impact of the world at 19 when she believed that she should emulate other wives and drive her husband to the top of his profession. But she found there was no prescription for marriage when the storms came in the form of mounting bills, and mounting quarrels, slander and jealousy. Her "togetherness" with Martin was a dying dream; how it was resurrected is this book's story.

Children Deprived of a Normal Home Life. 38 pages. Paper. United Nations, Department of Social Affairs. New York. 1952. Price 25 cents.

This pamphlet covers the problem of children without a normal home life—in very brief paragraphs, devoted to each aspect of the situation. The information given and the recommendations put forward are too much in outline form to be useful in themselves, but the references given and the broad coverage make the pamphlet valuable to those connected with the field involved.

Victory Over Fear. By JAMES BENDER. 236 pages. Cloth. Coward-McCann. New York. 1952. Price $2.95.

Dr. Bender, director of the National Institute for Human Relations in New York, is the author of several "How to . . ." books and of several speech correction books. He writes clearly and pleasantly. He uses non-technical language and his references to, and quotations of, many well-known persons make the reading more interesting.

His theme throughout the book emphasizes a common-sense approach toward the understanding of fear. He quotes William James as follows: "Common sense is not sense common to everyone; but sense in common things." As he describes and defines fears Dr. Bender calls attention to periodic mood swings and recommends that each person make his own mood swing calender so that he will know the best time to approach difficult problems, and so that he will recognize his low swings and not become panicky about them. Dr. Bender suggests, too, what can be called Coe's method of talking one's self out of fears and creating confidence in one's self. "Thus many of our fears are really apprehensions of what restitution or expiation will involve. We are torn between the realization that we ought to right a wrong we have done and the reluctance to pay the price. So long as we bear this conflict within us, we are a house divided against itself, and our self-respect suffers."

Fear of old age is a subject which the author discusses very nicely. He gives the oldster hope, courage and a plan of living. He recommends that older persons develop wider interests, make many new friends, marry again, take reasonable and sensible care of physical health, adjust finances to stretch dollars, seek part-time work, not give up education, and develop a sense of humor.

Other excellent chapters of the book refer to the fear of poverty, the fear of poor health, fear of expressions of love, fear of death and fear created in children by inconsistent parents.

Defense of Freedom. By the Editors of La Prensa. 315 pages. Cloth. John Day. New York. 1951. Price $4.00.

When a government fights a newspaper, the government, sooner or later, is going to win. This book is the chronicle of the struggle of *La Prensa*, one of Argentina's great liberal newspapers, to continue publication—a losing struggle, but no less memorable because of that. This book shows with great clarity the uses of mob psychology; and perhaps, may serve as a warning that such things do happen in previously free countries. The book is absorbing in those sections where it deals with the actual conflict with the Peron government, but tends to be somewhat flowery and pedantic in spots.

The Donkey Shoe. By G. B. Stern. 254 pages. Cloth. Macmillan. New York. 1952. Price $3.50.

The famous-actress lonely-daughter theme has been played ad nauseum by authors good and bad. Therefore, it is to G. B. Stern's everlasting credit that she can sweep the same strings with a difference.

Too often, modern novels degenerate into the bogs of sentimentalism when frustrated child and adolescent parent form a psychiatric case study. This time, both mother and daughter grow a little, and that little creditably, so that the reader can relax and identify with the child who always understood her artistic parent but couldn't show it, and with the mother whose first love belonged only to the theater. Thus we may criticize, but we cannot condemn Jessica's failure of her child in her early years; and can wince, even while we understand, her callous reference to her daughter before all admirers as "the little donkey." The donkey symbolism cuts a deep pattern in the unconscious of both mother and daughter . . . a pattern which every page of this brilliant novel reveals while one grows up with its characters, watching donkey and race horse run the course together.

The Steps of the Quarry. By Robert Tekrell. 350 pages. Cloth. Crown Publishers. New York. 1951. Price $3.00.

This is a remarkable book in these days of prevalent trash in literature. A series of realistically depicted characters, centering around a captured concentration camp in Austria at the end of the war in Europe in 1945, is used by the author to delve into the psychologic make-up of a few conflict-ridden soldiers and their girls.

There is a peculiar dichotomy between conscious and unconscious tributaries in this author. On the conscious level, a series of objections are justified. The book is aphoristically written, its polities are dubious or naïve, and sometimes a peculiar antipathy toward the United States is discernible. On the other hand, unconsciously, the author is capable of evoking the feeling of true compassion for some of his *dramatis personae*—and that is more than can be said of most of the unpsychological contemporary novels.

The Accuracy of Teacher's Judgments Concerning the Sociometric Status of Sixth-Grade Pupils. By Norman E. Gronlund. 62 pages. Paper. Beacon House. New York. 1951. Price $2.75.

It is found by the author that while there is a difference between the abilities of different teachers to estimate the sociometric status of their pupils, the only external factor that effected a change in this ability was a course in child development. While the material contained in this pamphlet is interesting, it is doubtful if any but specialists will find it sufficiently valuable to justify purchase—particularly at the price for which it is sold.

Psychoanalysis as Science. By E. R. Hilgard, L. S Kubie, and E. Pumpian-Mindlin. 158 pages. Cloth. Stanford University Press. Stanford, Calif. 1952. Price $4.25.

A compilation of three lectures, delivered at the California Institute of Technology, this book is highly unsatisfactory, and will please neither friends nor foes of analysis.

The psychologist on the team simplifies the ABC of analysis, tries to adduce inconclusive experiments, and bases his approach on "I do not care whether we end up believing that Freud was a scientist or a romanticist."

The analyst, though presenting the case for analysis, brings in so much of his own predilections and antipathies that his piece becomes more a personal credo than a general statement. And the biologist of the trio is rather condescending: "Whether one wishes to accord psychoanalysis the rank of a science or not depends upon one's personal point of view. Psychoanalysis must content itself at its present stage of development with establishing what appear to be significant, but not exclusive, correlations rather than specific causal relations."

The book can be summarized by stating that better arguments pro and con have been adduced by other investigators.

Annual Review of Psychology. Vol. III, 1952. Colvin P. Stone and W. Taylor, editors. 462 pages. Cloth. Annual Reviews, Inc. California. 1952. Price $6.00.

This is the third volume of this review. It presents a greater breadth of selection of papers from outside the United States; and, apparently, the hope is to increase this trend. The present collection covers a wide range of special fields, with excellent papers by several well-known, outstanding scientists. Despite its limitations in trying to cover a tremendously wide range of interests, it provides a superficial idea of new developments during the past year. However, it is questionable whether the best in this type of endeavor has been reached, or whether a similar review for each field might not be more appropriate in providing more comprehensive data for each area. Until the latter is possible, however, the present method serves a significant purpose.

Morning for Mr. Prothero. By Jane Oliver. 242 pages. Cloth. David McKay. New York. 1951. Price $2.75.

Equipped with modern gadgets, charts, a "psychotherapeutic department," "emotional recording apparatus for troubles in the whole world," with people "recorded in dominant colors, etc.," this is a novel about the "beyond." All this is seen through the eyes of an elderly British surgeon. The book seems intended to describe a conversion; but, despite his good intentions, the author's production will appear to many as only an inept blasphemy.

The Mount Sinai Hospital of New York. By JOSEPH HIRSH and BEKA DOHERTY. 285 pages. Cloth. Random House. New York. 1952. Price $5.00.

The history of the 100 years during which the Mount Sinai Hospital has been in existence will be enjoyed by all persons who have been associated in any way with it. Data for the book have been taken from the hospital archives, the meetings of the boards of trustees, the medical board, the annual reports, and from the hospital journal.

In a very pleasant style, the authors have recorded the many changes and events which have taken place. They have included many pictures of the hospital and of the men and women associated with it during the last century.

The appendices record the chronology, the names of past and present officers, trustees, superintendents, committee members, the present medical and surgical staff members and other important information about the events which have taken place at that institution.

Essays in Applied Psychoanalysis. Volume II. By ERNEST JONES, M. D. 383 pages. Cloth. Hogarth. London. 1951. Price 21/.

These essays use a psychoanalytic approach to the fields of folklore, anthropology, and religion—relating unconscious drives and associations to conscious beliefs and superstitions. A very broad base of knowledge is involved—the tracking down of a subject may lead from the Egyptian *Book of the Dead* to Welsh legends and back again, taking in Sanskrit word roots on the way. For thoroughness, the essay on "The Symbolic Significance of Salt" is remarkable. A study of the role of salt in fertility rites and other ceremonies and superstitions relates it, in the unconscious, to semen and urine. Several of Jones' articles deal with religion, some with present-day beliefs; and interpretation here may be considered highly controversial by many.

This book forms an important addition to the literature of non-clinical psychoanalysis. The style, though dealing with a complex subject, is of great clarity.

Paralysis Agitans. Acta Psychiatrica et Neurologica; Supplementum 54. By HENRY MJÖNES. 195 pages. Paper. Ejnar Munksgaard. Copenhagen. 1949. No price stated.

The author has studied the genetical aspects of paralysis agitans and concluded that there is a Mendelian mechanism. Inhibitions of manifestation are concluded to be the causes of the difference between the theoretical 50 per cent hereditary occurrence and the 30 per cent occurrence found. Supportive data are presented.

Psychoanalytic Theories of Personality. By GERALD S. BLUM. XVIII and 219 pages. Cloth. McGraw-Hill. New York. 1953. Price $3.75.

In *Psychoanalytic Theories of Personality*, Gerald S. Blum, the creator of the Blacky Picture Story Test, has attempted to present in an organized framework, the many diverse "psychoanalytic" theories of personality development and has purposed to evaluate these concepts from a scientific research point of view. The tenets of the leading theorists in the field, including those of the orthodox Freudians, the early dissenters, and the neo-Freudians, have been systemized by the author according to the chronological sequence of personality development, beginning with birth and eventually reaching adult character structure. The orthodox psychoanalytic theory receives the most coverage since, as Blum states, "It is the most carefully worked out." Although the author holds that many of Freud's original formulations are outmoded, he, nevertheless, severely criticizes the neo-Freudians, i. e., Horney, Fromm, Sullivan and Thompson, chiefly, it appears, for remaining in the fold, and paraphrasing many of the orthodox views with little reference or acknowledgment.

At the conclusion of each chapter, the existing evidence and research relevant to the divergent positions are evaluated by the writer in an effort to find the most applicable and worthy for future research explorations. These critical notes, as stated by the author, "are oriented primarily toward the research possibilities inherent in the content" and consist of "brief resumes of existing experimental data, suggestive evidence from related fields like cultural anthropology and learning theory, consideration of logical inconsistencies and semantic confusions, and comparisons of overlapping views."

What Blum actually succeeds in presenting is only a superficial, cursory and incomplete account of the salient psychoanalytic views. He should, nevertheless, be lauded for his endeavor to organize, by age levels, the many divergent and seemingly irreconcilable psychoanalytical theories and, more important, he deserves encouragement for his attempt to verify these concepts by existing research data in an effort to initiate the development of a sound and integrated theory of personality.

Mary Lincoln: Biography of a Marriage. By RUTH PAINTER RANDALL. xiv and 555 pages. Cloth. Little, Brown. Boston. 1953. Price $5.75.

By going to original sources, the author has pieced together the threads of Mary Lincoln's life and come forward with a picture that differs in many respects from the generally accepted one. Far from being the nagging shrew who made Lincoln's life and marriage miserable, she is shown here as the partner in an essentially happy marriage. The author believes her never to have been psychotic, or even close to it, but concedes that at times she was extremely neurotic in her actions.

I, William Sutton. By QUENTIN REYNOLDS. 273 pages. Cloth. Farrar, Straus & Young. New York. 1953. Price $3.50.

All who read this book will be intrigued by Willie Sutton's life and, at the same time, will feel very sympathetic toward him. As the expression goes, "He is a character!" He is a person whom no one can understand. He admits that he does not understand himself. The reader gathers that, in spite of all his illegal behavior, Sutton is sincere, and is morally good and honest in his illogical way. He is, in many ways, like the pyromaniac who cannot evade the temptation of setting fires. Sutton cannot evade the temptation of robbing a bank. This, and escaping from prisons, seem to have been his only "vices." It is regrettable that this intelligent, kindly and capable man has selected a career which places him behind bars for the rest of his life (unless he breaks out again, and his records show that this is a possibility).

Sutton has permitted Quentin Reynolds to record his autobiography on the condition that the money received from the sale of this book be ". . . put . . . into a trust fund of some kind to help kids during their difficult years, that might convince people that I was on the level." Sutton says that he wishes nothing for himself.

Speech Rehabilitation in Cerebral Palsy. By MARION T. CASS. 212 pages. Cloth. Columbia University Press. New York. 1951. Price $3.00.

Of the more than 1,000,000 speech-handicapped school children in the United States, the cerebral palsied have received the least consideration—due to public ignorance—yet there are 150,000 of them, and three-fourths of these are estimated to be educable.

Dr. Marion Cass, an outstanding authority, teacher and lecturer in this field, defines cerebral palsy as "a disturbance of the muscle function which has its origin in the brain."

Once people thought the cerebral palsied to be feeble-minded because limbs jerk and do not co-ordinate. Now such fallacies have been exposed; but there is a tremendous job of public education still to be done. In fact, New York and California are the only two of our 48 states that have actually granted money to alleviate the education inadequacies for this group.

Cerebral palsied children are emotionally unstable . . . a condition rooted in frustration caused by the disease itself (impairment of the inhibitory mechanism of the brain) plus parental overprotection and the public's general attitude of rejection. The earlier cerebral palsied children begin their training the better the results. Three-year-olds attend special classes in California.

Each case of cerebral palsy is an individual one. The *spastic* must be taught muscle relaxation. He is not so affectionate as the *athetoid* type, because physical petting actually hurts his muscles. The *athetoid* lacks control of the speech muscles. He must be taught control of joint motion. The *ataxic* child, on the other hand, has a sense of movement, but a poor sense of position, so that he cannot execute precise speech movements.

The type of program necessary to educate these children adequately as proposed by Dr. Cass, will involve the establishment of special classes where trained personnel will carry on medical and physical rehabilitation, correlation between the home and the school, and the establishment of classes for vocational training and guidance.

If schools like this can be established successfully in other states as they have been in New York and California, and if the public can be educated to see the value of this work, we shall have taken a step forward in reclaiming citizens . . . a project certainly as vital as the reclaiming of soil.

Parents, teachers and speech therapists will find numerous helpful exercises and suggestions for treatment in Dr. Cass' book.

Unquiet Minds. Leaves from a Psychologist's Casebook. By Dr. EUSTACE CHESSER. 232 pages. Cloth. Roy. New York. Price $3.50.

Dr. Eustace Chesser, British psychologist, well known for his previous book, *Love Without Fear,* recounts in this present volume some of the true case histories in his files. His approach is simple narrative and is interesting.

The rationales behind Dr. Chesser's approach to these cases are revealed in the introduction by the following statements: "We can no longer delude ourselves into believing that we really possess freedom of choice and action. . . . The general argument put forward by those with moderate views is that personality—and therefore behavior—is determined by our physical and emotional endowment which in turn are molded by the forces of environment and heredity. There is no exact time when the influence of one stops and that of the other takes over." In summarizing this nature-nurture influence the author says, "The argument, in the end, is less whether we are free or not but how far within the limits set for us we can be free and responsible."

The author chose eight cases from his files, each of which centered around a special theme, such as divorce, juvenile crime, prostitution, and suicide. He tells these stories from a factual, sympathetic position, neither explaining nor condemning but always illuminating them with his own strong belief in a Divine Being. He does not, in any instance, deal with means and methods of treatment or therapy. In a postscript he gives a follow-up on the case histories and a plea for a society which does not foster human misery.

Lesbia Brandon. By ALGERNON CHARLES SWINBURNE. With a commentary by Randolph Hughes. xxxv and 580 pages. Cloth. British Book Centre. New York. 1952. Price $7.50.

The most extraordinary thing about this book, by far, is the commentary. To anyone accustomed to the staid and reserved habits of literary critics Mr. Hughes' antics will prove a shock. This reviewer was amused and delighted to encounter here a man who is not in the least disturbed at calling previous "students" of Swinburne "incompetents," and "fools," and by reporting "the uncomfortable feeling that one is in the presence of cretinism." Mr. Hughes has done his own work, wherever it is at all possible, from the original sources, and exhibits a thorough knowledge of the subject. This reviewer is not in the position to set himself up as a judge of the accuracy of the conclusions drawn—but a reply from one or more of the maligned Swinburne scholars, none of whom Mr. Hughes has the slightest use for, should set the stage for a literary battle-royal.

As far as the treatment goes of the psychopathology, only too evident in the novel, this reviewer has few complaints. In his handling of a dream experienced by the hero of this novel—who is admittedly in many respects a personification of Swinburne himself—why does Mr. Hughes think it "improbable" that it could have been a dream Swinburne experienced, especially since it is—as it has been ably interpreted by Mr. Hughes—a classic example of unconscious sexual conflict? The novel itself shows Swinburne's preoccupation with flagellation as a means of expressing masochistic desires—which in Swinburne's case went beyond unconscious levels, and with the "incest *motif*," which probably did not rise above the unconscious level. The novel, which is incomplete and is published now for the first time, certainly should have been published—and before this—but there will be few who will place it on as exalted a level as does Mr. Hughes. Both from the point of view of the psychopathology evidenced, and from the literary standpoint it is worth reading, as is the commentary—though many readers may wish, with the reviewer, that at times Mr. Hughes would relax a bit. A little vitriol goes a long way, and there is far more than a little here. After all, not everyone believes that misrepresentation of an author calls for eternal damnation!

The Soviet Impact on Society. By DAGOBERT D. RUNES. xiii and 202 pages. Cloth. Philosophical Library. New York. 1953. Price $3.75.

To deny the very real menace of Communism to our free society would be an absurdity. On the other hand, the use of "labels" and "catch phrases" in the attack upon Communism is a habit to be deplored. Dr. Runes, instead of writing a study, has written a polemic, and in so doing has made this book of slight value to serious students of the subject.

Jung's Psychology and Its Social Meaning. By IRA PROGOFF, Ph.D. xviii and 299 pages. Cloth. Julian Press. New York. 1953. Price $5.00.

The main purpose of *Jung's Psychology and Its Social Meaning,* says the author, is to "facilitate the process of integrating Jung's concepts into the mainstream of contemporary thought." To accomplish this aim, Progoff attempts a comprehensive and systematic presentation of Jung's complicated and often inconsistent tenets in terms of an interpretation which the writer believes will make it possible for them to be critically evaluated and worked with in the related fields of psychology and social study.

Although this book deals mostly with the essential concepts that Jung uses to analyze the processes underlying psychic phenomena, the author does endeavor to present and elaborate upon the hypotheses which Jung generated, but did not develop, and their general influence in stimulating scholarly investigations in the fields of social science. Indeed, the importance that Progoff attributes to Jung's contribution to the understanding of culture and historical change is demonstrated by the writer's somewhat extreme conclusion, in which he states, "that Jung's concepts have a ground-breaking power for the social sciences, but that they will make their impact fully felt only when they have been reformulated and redefined with reference to the specific problem of social study. When this has been done, Jung's radical and profound penetration is bound to have a tremendous effect on the social study of man."

The Trouble with Cinderella. By ARTIE SHAW. 394 pages. Cloth. Farrar, Straus & Young. New York. 1952. Price $3.75.

Instead of viewing the kingdoms of the world and discarding them, Artie Shaw struggled and fought for them from the poverty of the East Side slums, up to the peaks of popularity as a top-flight American band leader. He made his first million several times over. In fact, it was just at that point, that Shaw stopped the music and sat down to think. He discovered that he had got on the merry-go-round of money and fame "out of my own inner weakness and Cinderella wishes."

Not until after he had left the Hollywood scene and had played a part in the World War II drama, did Shaw seek help through psychoanalysis where he admits, "a guy can learn a hell of a lot about himself, that he can learn in no other way."

This book is written thoughtfully, intelligently and with deep integrity. Shaw's style is as striking as his music. Like Thurber's sketches, his easily flowing lines reveal some very important truths about you and me and the ideals of mass taste. For those of us who suspect that the American dream of "$ucce$$" may be a nightmare in disguise, here are some substantiating facts.

Current Therapy, 1953. Latest Approved Methods of Treatment for the Practicing Physician. Howard F. Conn, M. D., editor. 800 pages. Cloth. Saunders. Philadelphia. 1953. Price $11.00.

As the title of this book indicates, it does not pertain to diagnosis; but, after a diagnosis is made, *Current Therapy* gives the doctor all he needs to know about the treatment of any disease. *Current Therapy* is far better than any ordinary textbook on therapy because it is up to date. The methods of treatment are discussed clearly, briefly and specifically. In many cases, methods are given by two or more contributors so that the reader has more than one doctor's opinion.

Current Therapy has over 370 contributors, most of whom are well known. In its 800 pages, it describes treatment of nearly all medical diseases. There are also a section which gives additional data on drugs mentioned, a table of metric and apothecaries' systems, and a table for making percentage solutions. The indices locate items, authors and contents accurately.

Child Psychiatric Techniques. By LAURETTA BENDER, M. D. 360 pages with index. Cloth. Thomas. Springfield, Ill. 1952. Price $8.50.

This is a valuable, comprehensive formulation of the care, treatment and observation of problem children gleaned from years of experience at the children's ward at the Psychiatric Division of Bellevue Hospital, by Bender, Schilder and others. A multitude of techniques are described, such as puppetry, clay modeling, figure drawings, visual-motor productions, and other expressive media.

The inclusion of a wealth of case studies, many followed longitudinally, gives the book greater meaning and value. Through utilization of the same cases in each chapter, the reader gains a valuable horizontal study by seeing the individual's reactions to the various techniques. The many illustrations further enhance the instructive potential of the volume. The material actually represents the contributions of several fields including psychiatry, psychology, education and art, and the book constitutes a useful reference volume.

Enardo and Rosael. By ALEJANDRO TAPIA Y RIVERA. xix and 56 pages. Cloth. Philosophical Library. New York. 1952. Price $2.75.

This little allegory deals with an angel who grew wearied with the placid life in Heaven and came to Earth in pursuit of the man she had come to love, Enardo. While in itself a minor piece of writing, *Enardo and Rosael* may serve to stimulate enough interest to have other works of this Puerto Rican philosopher translated.

Goya's Caprichos. By José López-Rey. 2 volumes, xv and 224 pages, and xiv and 265 pages. Cloth. Boxed. Princeton University Press. Princeton. 1953. Price $12.50.

The series of plates that Goya published under the title of "Caprichos" offers one of the most devastating satires—in dream-fantasy form—on the falseness and immorality of an age that has ever been produced. The author has used Goya's own explanations as the basis for his interpretations of the symbolization in the plates. While recognizing the dream origins of the series, the possibility that the plates might well represent an expression of fantasy life in Goya on a pathological level is not even mentioned—nor is there any attempt to explain Goya's preoccupation with certain forms of imagery, such as aerial flight and anal exhibitionism. Despite the fact that this book makes no excursions into the dynamics of the subject, those interested will find it invaluable—the inclusion of preparatory drawings among the plates, which comprise the second volume, and the commentaries on the plates contribute much to understanding.

No Postponement. U. S. Moral Leadership and the Problem of Racial Minorities. By John La Farge, S. J. 239 pages. Cloth. Longmans, Green. New York. 1950. Price $3.00.

In this book, Father La Farge sets forth his opinions relative to racial and minority problems. He informs the reader on what specific efforts the Catholic Church has made in an effort to alleviate the problems. He describes the history of the Catholic Interracial Council and what this organization has accomplished.

He expresses opinions which are shared by many, namely, that the government and the people of the United States preach tolerance but fail to abide by their preaching; that they are inconsistent in what they say and do; that other peoples of the world question the sincerity of their preachings.

Father La Farge proposes that the idea of white racial superiority and inconsistent dealings with underprivileged peoples everywhere should be repudiated; that United States citizens should familiarize themselves with these problems and demand appropriate legislation that "it is time for all of us to drop once and for all the notion that any simple, facile formula will serve to eradicate prejudice and implement the great principles of human justice and brotherhood; altho, as I have said, these principles in themselves are simple and clear. . . . The time for the human race to lift up its hope is now, not in the near or remote future. Each of us can begin to work for these ends in our own religious association in our own community for God's most holy sake."

New Play Experiences for Children. By RUTH E. HARTLEY, LAWRENCE K. FRANK, and ROBERT M. GOLDENSON. 66 pages. Paper. Columbia University Press. New York. 1952. Price 75 cents.

Growing Through Play. By RUTH E. HARTLEY. 62 pages. Paper. Columbia University Press. New York. 1952. Price 75 cents.

These two pamphlets are based on a project by the Caroline Zachry Institute for "an exploratory study of play in fostering healthy personality development by young children." This study itself was published in a volume entitled *Understanding Children's Play*. Such additional material as was felt to be of special interest and value to educators and guidance workers is presented in the two pamphlets reported in this review. *New Play Experience for Children* contains the observations of groups of nursery school children in exploratory projects with puppets and miniature life toys and in planned play groups. *Growing Through Play, Experiences of Teddy and Bud* presents running accounts of "Teddy's" and "Bud's" individual and group play experiences over a period of many months.

The two pamphlets are well documented by concrete material from the play sessions. The approach is more from a guidance level than a psychoanalytic. As a result, the interpretations of the data tend to be superficial and lack integration. However, the material should prove useful for presenting various techniques of play therapy and should be of benefit for teachers and guidance workers.

Monkey on My Back. By WENZELL BROWN. 270 pages. Cloth. Greenberg. New York. 1953. Price $3.50.

Mr. Brown's book brings the reader closer to the problem of narcotics addiction. In it he makes use of actual cases to show what factors led to addiction. The author not only stresses the importance of hospital care but also the need of psychiatric aid to help resolve the inner problems. He points out economic and environmental causes and also points to family relationships—all problems requiring aid, often psychiatric, before the addict can effect a permanent cure. Written primarily for the layman, and often dramatized, this book still remains a valuable work.

The Tender Age. By RUSSELL THACHER. 277 pages. Cloth. Macmillan. New York. 1952. Price $3.00.

Here is a well-written, though strange, book, depicting maturation-pains of a boy of 17. The family setting is unusual—a father who admits to, and continues, an extramarital affair. The author evokes sympathy for his hero; he is, however, incapable of explaining any of his reactions. Pity alone is inadequate; somewhere, somehow, between the lines, the real writer makes the unconscious of the reader understand what is really going on. Nothing of this is included in the rather pessimistic and atypical novel.

The Refugee Intellectual. By DONALD PETERSON KENT. xx and 317 pages. Cloth. Columbia University Press. New York. 1953. Price $5.00.

The immigrants to this country from Germany and Austria between the years 1933 and 1941 comprised a unique group in that they represented for the most part people who had made satisfactory economic adjustments in their own lands and were leaving them for political reasons. This book is a statistical survey of their degree of integration into the American culture and the effects, both financial and social, of the change. Sociology is a field where statistical studies have been, to a large part, lacking, and, as this book shows, the inclusion of statistics does not necessarily impair readability.

Dante's Drama of the Mind. By FRANCIS FERGUSSON. x and 232 pages. Cloth. Princeton University Press. Princeton. 1953. Price $4.00.

This is an interpretation of the *Purgatorio,* showing it to be the transitional section of the *Divine Comedy.* The author stresses the differentiation to be made between Dante the *author,* and Dante the *voyager*—with the *Purgatorio* representing Dante the voyager slowly rising above worldly thinking to a conception of spiritual values. The role of Virgil is taken to be that of the worldly enlightened, leading Dante on—but by the end of the *Purgatorio* Virgil has completed his mission and can go no further. The author acknowledges indebtedness to the works of Jacques Maritain and T. S. Eliot; and, throughout, this is primarily a study in religious concepts.

Selected Papers on Psychoanalysis. By KARL ABRAHAM, M. D. 527 pages. Cloth. Basic Books. New York. 1953. Price $6.00.

Psychoanalysis as a science is not a static thing—it, like the other sciences, has made great strides since its conception. For this reason, it is remarkable, not that some of the views of Karl Abraham have been superseded by later research, but that so many of his papers are applicable today. The emphasis in these papers is upon the purely clinical phases of the field. Any one interested in the history of the psychoanalytic movement will find this book invaluable; and, for that matter, provided the reader has a good background in the newer researches, there is much useful material from any standpoint.

Twins. By DOROTHY BURLINGHAM. 89 pages with 30 charts. Cloth. International Universities Press. New York. 1953. Price $7.50.

A study of three pairs of identical twins, this book is, from the theoretical standpoint, a rehash of the analytic ABC's, *anno* 1925. The pre-Oedipal phase of development is not included, or such "unimportant" topics as psychic masochism, and pseudoaggression. From a descriptive angle, the text is better; a series of detailed recordings from birth is included. Of interest, is the observation of the division in each pair of twins into one active and one passive partner.

Psychology and Alchemy. By C. G. JUNG. Volume 12 of the Collected Works. xxiii and 563 pages. Cloth. Pantheon. New York. 1953. Price $5.00.

One does not have to be an adherent of the psychological theories of Jung to derive value from this book. Apart from the psychological interpretations, there is a wealth of source material for the student. Non-Jungians will find the third section, dealing with "Religious Ideas in Alchemy" to be most valuable. Readers of this publication will not need to be told that Jung devoted an enormous amount of research to the study of comparative religion, and he has covered his subject with commendable thoroughness. There are 270 illustrations, all of good quality, in the book.

Satan's Children. By GEORGES SIMENON. 298 pages. Cloth. Prentice-Hall. New York. 1953. Price $3.95.

This book contains two short novels, and shows the French writer from his worst and best sides. The first story, *I Take This Woman,* is a miscarried attempt at depicting a schizoid woman. The second, *Four Days in a Lifetime,* is a brilliant description of a masochistic weakling whose "business" is extortion. Of course, despite fine psychological insight, all the typical weaknessess, characterizing Simenon's literary work, are amply represented: his impatience, lack of working out, preference for violence, etc. Nonetheless, the understanding of his masochistic characters is so penetrating that one gladly overlooks these minor nuisances.

Recollections of Andre Gide. By ROGER MARTIN DU GARD. 134 pages. Cloth. Viking. New York. 1953. Price $2.75.

The high claims made for this book as an aid to the understanding of the character of Gide are not borne out by the contents. The author makes the point that Gide "succumbed to the temptation of exonerating himself by some subtle chain of argument." In this case, while not exonerating Gide for any of his traits, such as masochism, homosexuality, or self-centeredness, there is reluctance throughout the book to relate incidents or cast light on subjects that have not already been dealt with by Gide himself. The resulting study is valuable as a supplement to already existing material, but does not shed light on many facets of Gide's personality.

World Enough and Time. By ROBERT PENN WARREN. 465 pages. Cloth. Random House. New York. 1950. Price $3.50.

This book is concerned with perverted ideals of truth and justice. The characters, while perhaps suitable for case studies, are not credible in the setting. Their motivations are strange and unrealistic. As usual, the author shows craftmanship in his writing, but he has loaded the book with so much extraneous detail as to impair the reader's train of thought.

Adrenal Cortex—Transactions of the Third Conference. Elaine P. Ralli, editor. 204 pages with 58 figures and 23 tables. Josiah Macy, Jr. Foundation. New York. 1952. Price $3.25.

This book, chiefly referable to the subject of adrenal cortical steroids, thrashes out the chaff in the experimental and clinical observations on the interrelations between hypothalamus, ACTH, adrenal cortical steroids and renal function. Although there are five major subjects for discussion by R. F. Pitts; G. W. Harris; D. H. Nelson; O. M. Hechter and R. G. Sprague, it is not long before the 24 participants, whose extensive experience in the subject cannot be doubted, start the ball rolling in the direction of clarification.

As a result of the informal discussions and free expressions which differentiate assumption from observations, the reader can get an up-to-date review of what can be and what cannot be accepted. Therein lies the value of the text—from biogenesis to the application of the steroids in clinical practice. It is recommended to anyone who is thinking about, or is using, these hormones.

The Therapeutic Community. By MAXWELL JONES, M. D., and associates. xxi and 186 pages. Cloth. Basic Books. New York. 1953. Price $3.50.

The preferred treatment for the neuroses has been psychoanalysis, but this long expensive process is limited as to the numbers it can handle. The project here described is an attempt to utilize techniques of group therapy in the treatment of psychoneurotics, with the emphasis on sufficient personality adjustment to enable the patient to make an economic adjustment successfully. The author shows himself to have an excellent orientation in analytic concepts, and applies them, on a limited scale, in therapy. Statistical evaluation of the results is lacking, but it is the opinion of the author, and also of the reviewer, that the project has shown promise and should be continued.

Personality Measurement. By LEONARD W. FERGUSON. xiii and 457 pages. Cloth. McGraw-Hill. New York. 1952. Price $6.00.

The weakest portion of this book is that dealing with projective testing. Only two of these tests, the Rorschach and the TAT, are dealt with, and the treatment is rather unsympathetic. Little cognizance is taken of the unique value of the projective techniques when dealing with personality disorders, and the author, in apparently rating the TAT over the Rorschach, does not take into account the limited range of usefulness of the TAT. The treatment of the many tests described is statistical, and the handling of the non-projective tests is fairly comprehensive.

The Bracelet. By BEATRICE PAGE. 248 pages. Cloth. Bobbs-Merrill. Indianapolis. 1953. Price $3.00.

This novel is the story of Jane and the antique gold bracelet given her in place of a wedding ring. It came to symbolize love that was not present in her childhood or marriage; and, in her relationship with her son by this marriage, symbolized only pain. Driven by guilt feelings concerning her father and former lover, she tries, in her old age, to atone by a reconciliation with her son. The technique of flashbacks is employed to reveal her former life. This reviewer feels that the book was drawn out unnecessarily, and that some of the force of the excellent writing was lost.

Ernest Hemingway. By PHILLIP YOUNG. viii and 244 pages. Paper. Rinehart. New York. 1952. Price $2.00.

More of a study of the motivations and techniques of Hemingway than a critical appraisal of his works, this book explores the Hemingway "hero" and relates him to Hemingway himself—showing the high degree of identification. Far from being the generally accepted hard-boiled he-man, this hero is shown to be a man who is hurt and afraid, taking reckless chances not through lack of fear but because of great fear. The tendency toward suicide is always there, as is the unconscious desire for death. Thinking is not a luxury that is permitted a Hemingway hero—there is too much danger that the effects will be disastrous. The author exhibits a knowledge of psychiatry, though one might question his clarity of thought regarding it.

Brothers and Sisters. By EDITH G. NEISSER. 241 pages with index. Harper. New York. 1951. Price $3.00.

This is a miscarried attempt at describing and explaining sibling rivalry. The reason for the failure is concentrated simplification, leading to concentrated naïveté. With minor exceptions, the author waters down or simply bypasses everything dynamic psychiatry has discovered. Wisdom's last words seem to be that a "certain amount of resentment, rivalry and jealousy is bound to occur"; the remedy seems to be found on the commonsense level. It is too bad that an unconscious part of the personality does exist. It complicates unnecessarily the life of authors and publishers.

Sexual Harmony in Marriage. By OLIVER M. BUTTERFIELD, Ph.D. 96 pages. Cloth. Emerson Books. New York. 1953. Price $1.50.

Those in the psychiatric field must guard against being hypercritical of sex education books designed for laymen. This reviewer feels that this book could be of value to many about to be married. It gives much of the essential information about sex, and stresses the desirability of a satisfactory sexual adjustment. The terms employed are those the average adult can understand. The style will be too flowery for many tastes.

Modern Headache Therapy. By ARNOLD P. FRIEDMAN, M. D. 164 pages. Cloth. Mosby. St. Louis. 1951. Price $4.00.

This book presents experiences in diagnosing and treating over 5,000 cases in three headache clinics of New York City. It presents the subject from the standpoint of the presenting and most prominent complaint. In one chapter, it shows to what extent certain investigations must be made for diagnosis. It is valuable for its references to underlying causes. The 15-page index would be worth more if some of the subjects referred to had more than a passing mention in the text. Results of therapy are not discussed, probably because of the need to treat the underlying conditions. For students, the book might be recommended.

Fright in the Forest. By BENN SOWERBY. 272 pages. Boards. Knopf. New York. 1951. Price $3.00.

The external action in this novel is at all times secondary to emotional reactions. A man's search for himself at times carries the reader along, but at other times the reader must flounder as best he can. As might be expected in a book of this type, there are psychological overtones, but not of sufficient import to warrant its reading on that basis alone. The general level is rather above average, and, as this is a first novel, it is not unreasonable to hope that the next effort will be one that can be recommended without qualifications.

Art and Technics. By LEWIS MUMFORD. 162 pages. Cloth. Columbia University Press. New York. 1952. Price $2.50.

The main theme of this book is the depersonalization of the individual, which is being brought about by the stress laid in our society upon the techniques of living, without sufficient emphasis being placed upon the person's need for self-expression. The author shows a good comprehension of modern psychological concepts. His attitude toward Freudian thinking, while not actively hostile, is that it too often tends to contribute to this depersonalization. The treatment of art forms is interesting in itself, but the major stress is placed upon art's place in society.

By the Same Door. By BLANCHE CHENERY PERRIN. 271 pages. Cloth. Macmillan. New York. 1951. Price $3.00.

Here is a naïve novel about a bossy woman, finally "reformed" by her adolescent son. That things do not happen that way, is another story. The author overdoes Wilde's witticism, "Lying, the telling of beautiful untrue things, is the proper aim of art." Unfortunately, these "beautiful untrue things" must correspond to unconscious facts; otherwise the writer is not a creative writer but a typewriter operator. Not the slightest attempt is made (in the text, or between the lines) to explain the heroine's aggression in this novel; only the most banal conscious motivations are adduced.

Women, Society and Sex. Prof. Johnson E. Fairchild, editor. 255 pages. Cloth. Sheridan House. New York. 1952. Price $4.00.

Anthropologists, psychiatrists, psychologists, a fashion editor, a college president and representatives from other fields and specialties here contribute the latest word on women in relation to today's social problems.

These writers first presented their ideas on the lecture platform of Cooper Union in the 1951-1952 Adult Forum. There was unusual interest in the lectures; and, in the case of several, disappointed crowds were turned away. The general reader can now enjoy the treatment of this appealing subject by the 13 lecturers who offer opinions which are thought-provoking, frequently conflicting, and without conclusions, but nevertheless stimulating.

Nobody's Child. By PHYLLIS HAMBLEDON. 283 pages. Cloth. Rinehart. New York. 1951. Price $3.00.

This is a naïve novel, dramatizing the unhappiness of a child of divorced parents. Horror after horror is piled up to demonstrate the commonplace: Happy homes are better than broken up homes. Nobody denies that divorce can increase the psychic burden of children; at the same time, it is conveniently overlooked that a bad marriage of the parents is just as unfavorable. The author exemplifies with a girl of 11—if harm was done to this child by divorce, it was done much earlier. Finally, the author places an exaggerated emphasis on reality, once more overlooking the fact that reality is only the raw material which can be eclectically and unconsciously used or misused. The book gives the uncomfortable impression that it is merely an exploitation of a popular topic; the technique is on the same level.

The Dividing Stream. By FRANCIS KING. 312 pages. Cloth. Morrow. New York. 1951. Price $3.00.

Mr. King's book is a rather boring and overextended novel about a few American and British tourists in Italy. It contains, however, a good textbook description of a masochistic couple; the drawback is that no inner motivations are provided. Mr. King must have studied the newer psychiatric literature; he understood the mechanics, not the dynamics. He ends with the desperate question: "Why do we cling so to the people who make our lives miserable, cling to our crosses instead of climbing off them?"

Taking the prevalent low level of contemporary literature into account, it is already an achievement when the proper questions are asked. Intuitive writers provide—without knowing it themselves—answers between the lines. This is not the case in this novel.

CONTRIBUTORS TO THIS ISSUE

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Dr. Kaufman has been clinical director of McLean Hospital, Waverley, Mass., and has been in private practice in Boston and New York City. He served in the United States army medical corps during World War II and rose in rank from major to colonel. He was neuropsychiatric consultant for Pacific Ocean Areas. He received the Bronze Star in 1944 and the Bronze Star with first oak leaf cluster in 1951.

Dr. Kaufman has been president of the American Psychoanalytic Association and the Boston Psychoanalytic Society and is the author of numerous psychoanalytic and psychiatric publications. He is at present neuropsychiatric consultant to the Surgeon General, Department of the Army; is president of the Mental Health Film Board of the National Association for Mental Hygiene and is a member of the New York State Mental Hygiene Council. He is a diplomate of the American Board of Psychiatry and Neurology. He is a fellow of the American Medical Association, the American Psychiatric Association and the New York Academy of Medicine, and is a member of various other professional societies.

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Dr. Miller served as a captain in the Royal Army Medical Corps from 1949 to 1951. He was a physician at Saskatchewan Hospital, Weyburn, Saskatchewan, during 1951 and 1952. Since July 1952, Dr. Miller has been a resident in psychiatry at Topeka (Kas.) State Hospital. He has published previous scientific articles on the subject of physiology; and he is author of a statistical assessment of results of treatment with penicillin of cases of venereal disease in the British Army.

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E. CUMMING, M. A. Mrs. Cumming was a social biologist attached to the psychiatric department of the Saskatchewan government at the time of her co-authorship with Drs. Derek H. Miller and John Clancy of the paper published in this issue of THE PSYCHIATRIC QUARTERLY. She is at present doing postgraduate work at Harvard University.

ROBERT R. SCHOPBACH, M. D. Dr. Schopbach, born in 1919, was graduated from Jefferson Medical College of Philadelphia in 1944 and certified by the American Board of Psychiatry and Neurology in 1950. After directing neuropsychiatric consultation service in the army he served

a three-year residency in psychiatry and neurology under the Veterans Administration Philadelphia Dean's Committee. He is now chief of the neuropsychiatric department of The Clifton Springs Sanitarium and Clinic, Clifton Springs, N. Y. He is a member of the Finger Lakes Psychiatric Society and the American Psychiatric Association. Other publications by Dr. Schopbach have appeared in *Growth, The Journal of the American Medical Association, Philadelphia Medicine,* and the *Archives of Neurology and Psychiatry.*

J. LAWRENCE ANGEL, Ph.D. Dr. Angel is associate professor of anatomy and physical anthropology at the Daniel Baugh Institute of Anatomy of the Jefferson Medical College, Philadelphia. He was born in London of Anglo-American parents and was trained at Harvard, from which he received his doctorate in anthropology in 1942. He has been engaged in research on the anthropology of chronic diseases with National Institutes of Health support. These research subjects have included constitutional study of hospital patients (hypertensives, hyperthyroids, arthritics, and the varicose, as well as the obese). He has undertaken a social biological history of the Greek people, ancient to modern, as revealed in examination of almost a thousand skulls and skeletons (made possible by Guggenheim and Wenner-Gren Fellowships).

MORTON WACHSPRESS, M. D. Dr. Wachspress is a member of the psychiatric staff of the 141st General Hospital, APO 1005. He is now 28 years of age. He received his pre-medical training at C. C. N. Y., and the University of Michigan; and his M. D. from Western Reserve University School of Medicine in June 1949. He interned at Maimonides Hospital, New York City, until July 1950. He had a psychiatric residency at the Northport VA Hospital until December 1950.

ALBERT BERENBERG, M. A. Albert Berenberg, at present clinical psychologist at the Osaka Army Hospital, Osaka, Japan, is 32 years old. He received his B. A. in psychology from New York University in 1946; his M. A. in 1948; and completed his doctorate training in clinical psychology there in 1950. He has, since his recall to active duty been assigned as clinical psychologist to the 382d General Hospital; the 141st General Hospital, and the Osaka Army Hospital, all located in the communications zone of the Far East.

AVROHM JACOBSON, M. D. Dr. Jacobson was chief of the neuropsychiatric service of the 141st General Hospital when the data was compiled for the paper, of which he is co-author, in this issue of THE QUAR-

TERLY. He took his B. A. at the University of Michigan in 1944; his M. D. at Tulane in 1944; he is 32 years old. He interned at Newark (N. J.) Beth Israel Hospital; and took a residency in psychiatry at Middletown (N. Y.) State Hospital. He then went on active duty with the army medical corps, attending the army school of neuropsychiatry in 1946; thereafter serving as psychiatrist at Mason General Hospital, West Brentwood, N. Y., and later at the Pentagon Dispensary. Upon discharge, he took a fellowship in psychiatry at St. Elizabeths Hospital in Washington, D. C. He attended the Washington School of Psychiatry and had training with the Washington-Baltimore Institute of Psychoanalysis in 1948-50.

Dr. Jacobson is certified in psychiatry by the American Board of Psychiatry and Neurology. He has been an instructor in clinical psychiatry at the Georgetown University of Medicine; he is a member of the American Psychiatric Association, the Washington (D. C.) Psychiatric Society, the American Medical Association and other professional societies. Following recall to active army duty in 1951, he was assigned as chief of neuropsychiatric service at the 382d General Hospital, the Nara Convalescent Center, Osaka Army Hospital, and 141st General Hospital, all in the Far East Command. He is now living in Asbury Park, N. J. He is author or co-author of a number of psychiatric contributions.

NATHAN S. KLINE, M. D. Dr. Kline is director of the new long-term interdisciplinary research project recently set up at Rockland (N. Y.) State Hospital. A native of Philadelphia, a graduate of Swarthmore College and Clark University, and a graduate in medicine of New York University, Dr. Kline was director of research at Worcester (Mass.) State Hospital when he was named to head the new Rockland project. Dr. Kline interned at Saint Elizabeths Hospital, Washington, D. C., held a psychiatric residency there and later did postgraduate work at Harvard, Princeton and Rutgers. He was assistant to Drs. J. Lawrence Poole and Fred A. Mettler in the co-operative brain surgery research project conducted by Columbia University and New Jersey State Hospital at Greystone Park. He is 36 years old.

The new research project which Dr. Kline now heads calls for the co-operation of at least eight medical and social science disciplines. It involves work in research psychiatry, psychology, endocrinology, biochemistry and nursing. Dr. Kline himself has been appointed to the department of neurology, College of Physicians and Surgeons, Columbia University.

NEWS AND COMMENT

GLUECK TO GIVE FIFTH HUTCHINGS MEMORIAL LECTURE

Dr. Bernard C. Glueck, Jr., director of the Sex Offender Research Project of the New York State Department of Mental Hygiene, and supervising psychiatrist at Sing Sing Prison, Ossining, N. Y., will deliver the fifth annual Hutchings Memorial Lecture on October 5, 1953 in the auditorium of the College of Medicine at Syracuse University. The title of his lecture is "Psychodynamic Patterns in the Sex Offender." The lecture is one of a series in honor of the late Dr. Richard H. Hutchings, former superintendent of Utica and St. Lawrence (N. Y.) state hospitals, and editor of this QUARTERLY. He died in October 1947.

Dr. Glueck is in private practice at Ossining and is an associate psychoanalyst at the Columbia University Psychoanalytic Clinic. He is a diplomate of the National Board of Medical Examiners and a diplomate in psychiatry of the American Board of Psychiatry and Neurology. He is a fellow of the American Psychiatric Association and a member of other professional organizations. The son of Dr. Bernard Glueck of New York City, Dr. Glueck, Jr., is a graduate of Harvard in the class of 1938.

The Hutchings Memorial Lectures are co-sponsored by the Dr. Richard H. Hutchings Memorial Trust Fund Committee, the Onondaga County Medical Society, the Syracuse Academy of Medicine and the College of Medicine, Syracuse University. Dr. Hutchings taught at Syracuse for many years, where he was professor of clinical psychiatry at the College of Medicine.

Last year's memorial lecturer was M. Ralph Kaufman, M. D., chief psychiatrist at Mt. Sinai Hospital, New York City. Previous lecturers were Robert A. Cleghorn, M. D., associate professor of psychiatry at McGill University, who delivered the 1951 memorial lecture; Harry C. Solomon, M. D., medical director of Boston Psychopathic Hospital, who lectured in 1950 and Winfred Overholser, M. D., superintendent of St. Elizabeths Hospital, Washington, D. C., who initiated the series with the 1949 lecture. Members of the medical profession and students of medicine are invited to the lectures. Dr. Glueck's lecture, like the four which preceded it, will be printed in a forthcoming issue of THE PSYCHIATRIC QUARTERLY.

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STATE HOSPITAL ALUMNI ELECT

Clarence P. Oberndorf, M. D., was elected president, Richard L. Frank, M. D., vice-president, and Samuel R. Lehrman, M. D., secretary-treasurer, at the annual meeting of the New York State Hospital Medical Alumni Association.

GÉZA RÓHEIM, PH.D., PSYCHOANALYST, DIES AT 61

Géza Róheim, Ph. D., of New York City, internationally known psychoanalyst and anthropologist, died on June 7, 1953 in Mt. Sinai Hospital, New York City, after a week's illness. He was 61 years old. Born in Budapest, Dr. Róheim became a psychoanalyst through the personal influence and interest of Freud. The possessor of an international reputation before he came to the United States, he had made his home in America since 1938.

Dr. Róheim was on the staff of the Hungarian National Museum from 1917 to 1921. He was a practising psychoanalyst in Budapest in 1927 and 1928. From 1929 to 1932 he was engaged in field work in anthropology, sponsored by Marie Bonaparte, in Somaliland, Central Australia, Normanby Island and among the Yuma Indians. He was a training analyst and lecturer in psychoanalysis at the Budapest Psychoanalytic Institute from 1932 to 1938 and a guest lecturer at the Berlin and London psychoanalytic institutes. He was a teaching assistant at Worcester (Mass.) State Hospital in 1938 and 1939, a lecturer at the Rand School, New York City, in 1940. He was a guest lecturer at the New York Psychoanalytic Institute and an honorary member of the New York Psychoanalytic Society. He did field work among the Navaho Indians in 1947. He published approximately 250 papers in English, German, Hungarian, French and Spanish. His books include *Australian Totemism; Animism, Magic and the Divine King; Primitive High Gods; The Riddle of the Sphinx; The Origin and Function of Culture; War, Crime and the Covenant; The Eternal Ones of the Dream;* and *The Gates of the Dream,* published just after his death. He was managing editor of the annual *Psychoanalysis and the Social Sciences.*

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WILLIAM B. NOYES, M. D., MENTAL SPECIALIST, DIES AT 87

Dr. William B. Noyes, one of the oldest active practitioners in the field of mental and nervous disorders, died at his home in New York City on June 20, 1953 at the age of 87. Dr. Noyes, born in New Jersey, a graduate of Amherst and of the College of Physicians, Columbia University, studied at Berlin and Vienna before engaging in his years of practice in New York. His field of particular interest was mental deficiency in childhood.

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ENGEL IS PRESIDENT OF PSYCHOSOMATIC SOCIETY

George L. Engel, M. D., was elected president; Lawrence S. Kubie, M. D., president-elect, and Theodore Lidz, M. D., secretary-treasurer at the annual business meeting of the American Psychosomatic Society on April 18, 1953. Elected to the council of the society were Robert A. Cleghorn, M. D., Jacob E. Finesinger, M. D., and Jurgen Ruesch, M. D.

MENTAL HEALTH ASSOCIATION FINANCES RESEARCH

A program for direct allocation of grants for research on mental illness, in a large-scale financing program, has been announced by the National Association for Mental Health. The plan, just adopted by the board of directors, is announced by Robert M. Heininger, executive director of the association. It represents a new departure in the policy of the organization, which, except for sponsorship of research on schizophrenia, for which the 33rd Degree Scottish Rite Masons also contributed, has confined its efforts largely to encouraging research and offering consultative services.

The new association policy, it was announced, will mean that funds will have to be raised by the association on a much larger scale than ever before. Preliminary planning on the research program is to get under way this coming fall. The new plans were adopted on the recommendation of Thomas A. C. Rennie, M. D., chairman of the association's professional committee and professor of psychiatry at Cornell University Medical College. As a part of the general project, a commission for research on mental illness will be named from leading figures in psychiatry, associated fields, and government circles. The commission will study the research projects now being carried on, recommend the spots where new research is most urgently needed, and recommend allocations of funds.

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JUVENILE COURT STANDARDS REVISED

A revision of juvenile court standards to emphasize the protective nature of juvenile court proceedings, the necessity of avoiding rigidity in handling the social and emotional problems of children, and the placing of more emphasis on the legal rights of children and their parents, is being prepared by the Children's Bureau, United States Department of Health, Education and Welfare and the National Probation and Parole Association. The announcement by Dr. Martha M. Eliot, chief of the Children's Bureau, says that in preparing the revised standards a group of some 30 experts, including juvenile court judges, probation officers, directors of voluntary and public child welfare agencies, and lawyers, recently spent a three-day conference in Washington, going over a draft of revised standards.

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WALTER GOLDFARB, M. D., PSYCHIATRIST, DIES AT 43

Dr. Walter Goldfarb, New York City psychiatrist, died in New York City of a heart attack on June 4, 1953. A graduate of Yale Medical School, Dr. Goldfarb served in World War II as a lieutenant-colonel in the army medical corps. He was the author of numerous psychiatric articles, among them contributions to this QUARTERLY.

ROBERT V. SELIGER, M. D., ALCOHOLISM AUTHORITY, DIES

Robert V. Seliger, M. D., psychiatrist and nationally known authority on alcoholism, died in Baltimore, April 24, 1953, following a cerebral hemorrhage. He was 52 years old. Dr. Seliger, born in New York City, was graduated from Fordham and the University of Maryland, from which he received his medical degree. Long associated with the Johns Hopkins Hospital and the Johns Hopkins University Medical School, he was director of the National Committee on Alcohol Hygiene, Inc., and was the author of *Alcoholics Are Sick People*, and other works on alcoholism and psychiatry. He was president of the Medical Correctional Association, an affiliate of the American Prison Association; was a fellow of the American Psychiatric Association, and a member of other professional organizations. He leaves his widow, a son and a married daughter. Among his numerous writings, he had been a contributor to this journal.

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NEURO-PSYCHIATRIC CENTER COMPLETES THIRD YEAR

More than 9,000 psychiatric treatments, besides psychological tests, social service interviews, diagnostic consultations and neurological examinations have been carried out during the first three years of the New York Neuro-Psychiatric Center, the officers of the institution have announced. The Center, established in 1950 by William D. Sherwood, M. D., professor and chairman of the department of neurology and psychiatry at Columbia Post-Graduate Medical School and Hospital, and associates, now has a staff of 20 psychiatrists in addition to members of other disciplines. The Center is said to be the only psychiatric clinic supported entirely by patients' fees, which start at $6.50 and are based on ability to pay.

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TEN MILLION PAMPHLETS DISTRIBUTED

The ten-million mark in the distribution of mental health educational leaflets and pamphlets has been passed by the National Association for Mental Health, it has been announced by Robert M. Heininger, executive director. The association, organized three years ago, reports an increasing demand for this material and notes that the greater part of it is being used by newspaper and magazine writers, teachers, clergymen, nurses, doctors, social workers and industrial mental health personnel.

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RICHARD H. HUNGERFORD, *Editor*

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